Patient: ______________________________ Date: ________________________

Payment Options

Option #1: Payment in full by first surgical visit

Option #2: 50% payment by first surgical visit, remaining 50% over the next 3 months

Option #3: 50% payment by first surgical visit, remaining 50% the following month

Option #4: **Care Credit Financing**, additional information as needed

I choose payment Option #____. Please charge my card on the 1st or the 15th of the month until my balance is paid in full. Estimated patient portions are subject to change in accordance to insurance payment.

Estimated Patient Portion $_________________ Case fee $__________________

Today's Payment:

Payment 1: $______________ Date: _____________________

Payment 2: $______________ Date: _____________________

Payment 3: $______________ Date: _____________________

Westchester Oral & Maxillofacial, PLLC
19 Bradhurst Avenue, Suite 2500N, Hawthorne NY 10532
914-592-0440

Credit Card Authorization Form

I, (Cardholder) authorize Westchester Oral and Maxillofacial Associates, PLLC to charge the remaining balance on my account as specified above. Charges will be made on either the 1st or 15th day of the month as agreed upon until payment is complete.

Card Number:________________________ Expiration Date:________Security Code: _____

Cardholder Billing Address:

____

____

I have read, understand and agree to the terms listed above:

Signature ____________________________________ Date______________________________

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