Credit Card Payment Authorization Form

Sign and complete this form to authorize **Renumi Mobile Dental Inc** to make a one time debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize Renumi Mobile Dental to charge my credit card
(full name)

account indicated below for _____ . **LAST 4 DIGITS** OF CREDIT CARD:_____
(amount)

Billing Address _____ Phone#_____

City, State, Zip _____ Email _____

PLEASE PLACE A COPY OF DRIVERS LICENSE OR GOVERNMENT ISSUED IDENTIFICATION

****Occasionally insurance companies send Dental/Medical insurance claim checks to the subscriber to be reissued/forwarded to the treating Doctor.**

Depositing these claims and keeping the insurance benefit is against the law.

By signing below you are agreeing that upon the receipts of any claims RENUMI Inc will be contacted and any outstanding/deposited claims will be placed into collections and may affect your credit.

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above and is valid for one time use only. As discussed, once scheduled a cancellation fee of $185 will be charged if the patient leaves the center and cannot receive care.I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.