Sonny Aryan D.D.S.
4501 Mission Bay Dr. # 2E
San Diego, CA 92109
Phone: (858) 270-6626
Fax: (858)270-6625

Credit /Debit Card Authorization Form

Patient Name: _____ Patient Birthday: _____

Card Type: (Visa / Master)

Cardholder Name: _____ Cardholder's SSN: _____

Cardholder's Billing address:_____

City _____ State _____ Zip code _____

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____/_____ Verification Code (Back of Card): _____

Amount: $_____

I, _____, authorize Dr. Aryan to manually charge my Credit Card/ Debit Card on a monthly basis. I certify that this is my credit/Debit card and that by signing this agreement on behalf of_____. I am legally authorized to give permission for its use to your dental office. I understand that once the treatment gets started, our dental office will not be entitled to any refunds and that I agree not to dispute the resultant charges.

15% interest will be automatically charged if I fail to make a payment by due date. If our office is unable to obtain the total amount payment agreed by the next 10 days from the date of last payment, our office will report to collection agency and also will file a law suit.

Cardholder Signature: _____ Date: _____

Dr. Aryan will keep all information entered on this form strictly confidential.