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# PAYMENT AUTHORIZATION

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White, Roan & Associates  
2590 Park Center Boulevard Suite 100  
State College, PA 16801  
(814) 234-6826

I authorize White, Roan & Associates to keep my signature on file and to charge my credit card listed below for

- \_\_\_\_\_ Payment of my account balance
- \_\_\_\_\_ Co-payments AND/OR balance after my insurance has paid
- \_\_\_\_\_ Monthly installments toward my on-going treatment. (Orthodontics ONLY)

I assign my insurance benefits to the providers of White, Roan & Associates. I understand that this form is valid until I cancel it through written notice to the provider.

PATIENT NAME/NAMES:

\_\_\_\_\_  
\_\_\_\_\_

<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> CARE CREDIT
CARDMEMBER NAME (As it appears on card)			
_____			
CARDMEMBER BILLING ADDRESS:			
_____			
_____			
_____			
ACCOUNT NUMBER: _____ - _____ - _____ - _____			
EXPIRATION DATE: ____ / ____			
CARDMEMBER SIGNATURE: _____ DATE _____			