Thank you for choosing our practice for your dental needs. Please provide credit card information in case of **no show or late notice** cancellation policy.

Patient name:

Name of responsible party:

Address:

Phone:

**I authorize (Infinite Dental Wellness) to charge my credit card as specified below:**

\_\_\_\_\_ Charge my credit card for the unpaid balance because of No show to my appointment or not giving 48 hours cancellation notice. Also applies to late notice rescheduling.

Credit card type:  Visa  MasterCard  American Express  Discover  Other

Credit card number: Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card holder signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card holder name printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_