FAMILY DENTISTRY – IGOR KAMPFER, DDS, LLC
8800 LOCKWOOD, SKOKIE, IL 60077

AUTHORIZATION TO CHARGE SERVICES

As the cost and time involved for billing has risen greatly, we request that you allow our office authorization to generate charges to your credit card for any unpaid balance.

Please note: An invoice will be issued and mailed if there is a balance remaining after insurance payment. If you fail to respond to our invoicing, an attempt by phone call for authorization of payment will be made before changing your credit card.

I _____ authorize Dr. Igor Kampfer's office to process my credit card for any payment or balance due on my account.

VISA MASTERCARD DISCOVER

CARD# _____

EXPIRATION DATE _____ V-CODE _____

ZIP CODE _____

Name as it appears on the card

Signature _____ Date ___/___/_____