David E. Stall, D.M.D., P.C.

1646 West Chester Pike, Suite 1, West Chester, PA 19382
(610)692-8454

Preauthorized Health Care Payment Agreement

Dr. Stall and/or his associates have my permission to keep my signature on file and to charge health care fees to my:

☐ VISA ☐ MasterCard ☐ Amex ☐ Discover Account

For any charges not paid by my insurance within 45 days and as detailed below:

YES	NO	
☐	☐	Any other unpaid balance on account.
☐	☐	Payment plan - charge $_____ each month for _____ months.
☐	☐	Other _____.

Patient Name: _____

Card Holder Name: _____

Credit Card Number:_____ Exp. Date:____ Sec. Code:____

Card Holder Billing Address:

_____

_____

Card Holder Signature:_____ Date: _____