LESTER A. LEBLANC, D.D.S., P.C.
LEBLANC ORTHODONTICS

1415 Boston Post Road
Larchmont, New York 10538
(914) 833-2306

559 Gramatan Avenue
Fleetwood, New York 10552
(914) 668-8880

CREDIT CARD AUTHORIZATION FORM

Patient Name:_____

Cardholder Name:_____

Billing Address:_____

Credit Card Type:

☐Visa ☐MasterCard ☐American Express

Credit Card Number

_____ - _____ - _____ - _____

Expiration Date: _____ / _____

Card Identification Number:_____
(last 3 digits located on the back of your card)

TABLE FOR OFFICE USE ONLY

DATE	AMT	DATE	AMT

Amount To Be Charged Each Month: $_____

****Please note that charges are done at the beginning of each month and not on any specific day.**

I hereby authorize Lester A. LeBlanc, to charge the above amount to my credit card each month for orthodontic services.

_____ _____
AUTHORIZED SIGNATURE DATE