Anthony Parisek, DDS
Family Dentistry & Orthodontics

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EZ-Pay Credit Card Authorization

Name on Card (Please print): _____

Credit Card #: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Exp: ☐☐ / ☐☐   **Is this an HSA card?: Yes   No**

Initial Here	I, authorize Dr. Parisek's office to securely store my credit card information.
Initial Here	I ask that EZ-Pay auto-charge be setup such that: <u>AFTER</u> I have received my dental benefits, my card is charged as follows, based on where I initial

	Option	Allows you pay **AFTER** you receive your dental benefits check	Convenient	Effortless	What's Paid
	EZ-Pay++	✅	✅	✅	Insurance portion + Remaining balance
	EZ-Pay+	✅	✅		Insurance portion only
	Web Payment	✅			Amount you enter
	Statement	✅			Payment is due upon receipt

Signature: _____   **Date:** _____