Frank R. Helm, dmd, msd
Orthodontics for Children and Adults
3931 Grand Avenue | Oakland CA 94610 | 510.653.2205 fax: 510.653.1851
fhelmortho@gmail.com helm-ortho.com

Financial Agreement Pre-Authorization

Patient Name: _____

Responsible party name: _____

Address: _____ Work phone: _____

_____ Home phone: _____

I authorize the office of Dr. Frank R. Helm to charge my credit or debit card as detailed below:

❑ **Continuous Authorization**

Please keep this signature on file to cover any unpaid balance after insurance payment for any treatment performed in this office.

❑ **One-time Authorization**

Please cover any unpaid balance after insurance payment only for this current treatment.

❑ **Payment Plan**

Charge $ _____each month for _____months.

Payments will be on the _____of each month beginning _____.

Credit Card: ❑ Visa ❑ Mastercard ❑ Discover/Novus

Card #: _____ Exp: _____

Security code: _____

Cardholder signature: _____

Printed name: _____

Staff initials: _____ Date: _____

1 copy to patient, file original in chart