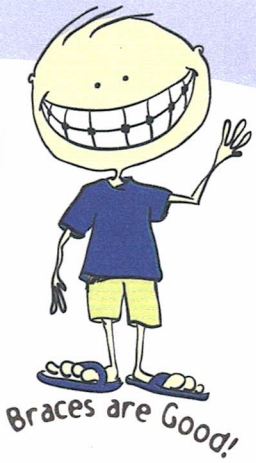
DeMaio Orthodontics




# CREDIT CARD CHARGE AUTHORIZATION

Date:_____

Patient Name:_____ Responsible Party:_____

I, _____, give permission to DeMaio Orthodontics to charge my VISA or

MASTERCARD account # _____Expiration Date _____

In the amount of $_____ per month beginning on _____28th, 20_____and to

continue until the balance on the account is paid in full.

_____(Print Name)

_____(Signature)

_____(Email address for receipts)

Please be advised that charge payments will be processed on the 28th of every month or the following business day. Receipts will be sent to the email address listed above.

264 Elm Street • Northampton, MA 01060
tel: 413-586-0555

23 Pray Street • Amherst, MA 01002
tel: 413-548-8822