Bella Smile Dentistry
2720 SW 97th Ave #101 # 101, Miami, FL 33165
(786) 534-6920
www.bellasmiledentistry.com/

DEBIT/CREDIT CARD PAYMENT AUTHORIZATION FORM
| DOB:

Please complete the following information to authorize the use of your credit card for payment at Bella Smile Dentistry.

Full Name of Cardholder (must match patient name):	
Card Type:	
Card Expiry Date:	

Billing Address:

Street Address:	
City:	
State:	
Zip Code:	

TERMS & PAYMENT AUTHORIZATION

Treatment & Balances

I authorize Bella Smile Dentistry to charge my card for services rendered and any balances not paid at the time of service.

Insurance Estimates & Pending Balances

I understand that dental insurance benefits are **estimates only**. I authorize Bella Smile Dentistry to charge the card on file for **any remaining patient balance** resulting from:

- Insurance underpayment or denial
- Deductibles, co-payments, or co-insurance
- Non-covered or downgraded procedures
- Treatment completed but not paid in full by insurance

Charges may be processed **within 30 days of insurance adjudication**, and a receipt will be provided.

Cancellation & No-Show Policy

Hygiene Appointments

Appointments canceled or rescheduled with less than **24 hours' notice** are subject to a **$35 late cancellation fee**, which will be charged to the card on file.

Doctor Appointments & Reserved Clinical Time

Doctor appointments require **48 hours' notice** for cancellation or rescheduling.

Certain doctor appointments require a **reservation fee** to secure dedicated clinical time. The reservation fee is **$50 per hour of scheduled doctor time** and will be **applied toward treatment on the day of service**.

If the appointment is canceled or rescheduled with less than **48 hours' notice**, the reservation fee will be **forfeited**.

Patient's signature: Date: