

# FINANCIAL DEPOSIT FORM

Please download this form and fax to 1- 305-279-2649 once signed and completed.  
If you need information with this form, call 1-305-279-1643

NAME: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

---

I, \_\_\_\_\_ authorize the Advanced Center for Cosmetic & Reconstructive Dentistry to charge my credit card for a deposit in the amount of US Dollars \$2,500. This deposit is to cover only preliminary evaluations, estimates and the examination fees to be done on the first day of the actual visit. A full fee will be given to me after the complete examination and only an estimate has been given to me so far.

I also accept that if after signing this form I decide not to move forward with the treatment, I forfeit US 1,500 Dollars and will have 1,000 refunded to same charge credit card or format. I shall **not** request a charge back for whatever reason on this fee. This entire fee shall be applied to the case fee if and when I decide to go through with the recommended treatment for my Smile Makeover.

\_\_\_\_\_  
Responsible Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Credit Card Number

\_\_\_\_\_  
Security Code

Type of card: VISA MASTERCARD AMEX DISCOVER CARE CREDIT

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Name as it appears on card

\_\_\_\_\_  
Billing address for the same credit card