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## Larry D. Murphy DDS

### Signature on File

“CONFIDENTIAL” Authorization Form

\_\_\_\_\_  
Patient Name (If this should apply to other family members, Please list.)

\_\_\_\_\_  
Card Holder Name:

Visa    MasterCard    Discover

\_\_\_\_\_  
Card Number  
Date

\_\_\_\_\_  
Expiration

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

\_\_\_\_\_  
Address  
Code

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Telephone #'s:

\_\_\_\_\_  
Home

\_\_\_\_\_  
Work

\_\_\_\_\_  
Cell

The Dental Practice Of:

**Larry D. Murphy DDS**

Is authorized to keep my signature on file and to issue a **credit and/or a charge** memo to my credit card for an outstanding balance. After insurance payment and/or correspondence have been received and applied to my account, any balance over **60 days** will be directly applied to the credit card on file. For charges in excess of \$500.00 we will notify you by telephone.

**Date:** \_\_\_\_\_

**Authorized:** \_\_\_\_\_

**Responsible Party**

**Date:** \_\_\_\_\_

**Authorized:** \_\_\_\_\_

**Witness**