Credit Card Number: _____

Expiration Date: _____

3 Digit Security Code (on the back of credit card) _____

Name on Card: _____

Amount to place on card: $_____ for Account # _____

By signing below, I authorize Dr. Dworetsky to charge the co-pay due, (as indicated by my insurance) at the time of my appointment(s) to the credit card listed on this form:

_____ _____

Signature Date

Billing address if different than on your account with Dr. Dworetsky:

Call 720.493.1380 for questions
Mail or fax form to secure fax machine: 303.721.8820

7535 East Hampden Avenue ♦ Suite 351 ♦ Denver, CO ♦ 80231