KENYU TAKAMOTO DDS, MSD
1811 156th Ave NE #1
Bellevue, WA 98007
(425)746-8676

Credit Card Information

Please choose one of the followings;

☐ A

I authorize Dr. Kenyu Takamoto (Health Care Provider) to keep my signature on file and charge my credit account for the balance of charges not paid by insurance within forty five (45) days after receiving the first payment from insurance company.

I assign my insurance benefits to Dr. Takamoto. I understand this form is valid unless I cancel the authorization through written notice to the health care provider.

Patient Name:_______________________________
(Printed)

Type of card : [ ] VISA [ ] MASTER

Card Number:________-_________-_________-_________ Exp:____/____ V code_______
(3 digit number on reversed side)

Cardholder Address:___________________________________ City____________Zip________

Cardholder Signature:______________________________ Today's Date:__________________

Check ☑ one, please.

☐ I authorize to charge my portion to my credit card automatically. (After we bill your credit card, we will send you a customer copy.)

☐ Please send me a statement first.

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☐ B

I understand and agree to pay full amount for the treatment at the time of check-out.
(If you have a dental insurance, we will submit a claim to your insurance company, the benefit will be assigned to you.)

Patient Name:_______________________________
(Printed)

Signature: _________________________________ Today's Date: __________________
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