

**Family & Cosmetic Dentistry, P.A.**  
**BERTRAM J. HUGHES, D.M.D.**  
**316 SW 16<sup>th</sup> Avenue**  
**Gainesville, FL 32601**  
**(352) 378-3323**

**Third Party Credit Card Authorization Form**

I, \_\_\_\_\_, hereby authorize my credit card

Type card: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Exp: \_\_\_\_\_

CID/CVV: \_\_\_\_\_ Zip Code: \_\_\_\_\_

to be charged in the amount of \$ \_\_\_\_\_. These charges are for

the treatment of (patient name) \_\_\_\_\_

and I agree that these charges are authorized by me.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

*Please fax back to us at (352) 378-0323. **Please call before faxing** so that it can be received properly. Or you may email to us at [info@DrBertHughes.com](mailto:info@DrBertHughes.com).*