

**Credit Card Payment Authorization**

Patient's Name: [REDACTED]

Credit Card: Visa \_\_\_\_\_ Mastercard \_\_\_\_\_ Discover \_\_\_\_\_ AMEX X

Card Number: [REDACTED]

Expiration Date: 6/21 Security Code: 9049

Name as it appears on credit card: JEFFREY EPSTEIN

Billing Address for card: 9 EAST 71ST ST.  
NY, NY 10021

PAYING FOR [REDACTED] CLEANING JAN. 17, 2018

I \_\_\_\_\_, the above named account holder, authorize \$ \_\_\_\_\_ to be charged monthly to my credit card on the 1<sup>st</sup> business day of each month for orthodontic services rendered in accordance with my contract with MJR Dental Services LLC. The first charge will occur on \_\_\_\_\_. I hereby acknowledge that the amount withdrawn in any given month may vary should other charges be incurred, but in no event will the amount to be withdrawn exceed the current amount due.

Once the automatic charge is activated, this transaction will occur on the 1<sup>st</sup> business day of every month until my account is paid in full. I understand that if the payment is declined for any reason, a \$39.00 fee will be applied to the account, and I will promptly remit the total monthly payment due. If payment is no received by the last business day of the month, a \$50.00 late fee will be applied to the account. I may cancel this authorization by notifying Dr. Jeffrey Rappaport in writing 30 days before the scheduled payment is due.

Date: JAN. 17, 2018

Signature of account holder: [Handwritten Signature]