COLLABORATIVE
DENTAL LABORATORY SERVICES
748 STATE ROUTE 28, SUITE B | MILFORD, OHIO 45150

Credit Card & Payment Authorization

FOR AUTOMATIC PAYMENT WITHDRAWAL

- ☐ **AUTHORIZATION TO KEEP CREDIT CARD INFORMATION ON RECORD**: You authorize for your Credit Card listed below to be kept on file.
- ☐ **RECURRING CHARGE AUTHORIZATION:** You authorize regularly scheduled charges to your Credit Card. You will be charged the balance due/amount indicated on each monthly statement you receive, each billing period (noted below). A receipt for each payment will be provided to you, and the charge will appear on your Credit Card Statement. You agree that no prior notification will be provided, and that each monthly statement you receive will act as notification to charge your Credit Card on file.

I, _____, authorize Collaborative Dental Laboratory Services to charge my Credit Card (listed below) for my balance due beginning (month/date) _____. I am aware that the Credit Card will only be charged if there is a balance due and will be charged monthly, as needed.

***By signing this form, you are giving permission to store your credit card information on file. You are also authorizing you Credit Card to be debited the balance due/amount indicated on each monthly statement you receive beginning on the date indicated above. All charges to your Credit Card will happen at time of billing period indicated below.*

_____ _____
Signature of Authorized Individual/Cardholder *Date*

TO STORE YOUR CREDIT CARD INFORMATION

- ☐ **AUTHORIZATION TO KEEP CREDIT CARD INFORMATION ON RECORD**: You authorize *ONLY* for your Credit Card listed below, to be kept on file. Prior notification (verbal/written) will be given to Collaborative Dental Laboratory Services for any charges to be made to your Credit Card. Collaborative Dental Laboratory Services may not make charges on your behalf, without this notification.

***By signing this form, you are giving permission to store your credit card information on file only. Your signature does not provide authorization for our billing department to charge your Credit Card without prior notification (verbal/written).*

_____ _____
Signature of Authorized Individual/Cardholder *Date*

Billing Details

Services Rendered: *Dental Laboratory Services*

Billing Period: *Monthly; Statements sent the first week of each month for the previous month's services rendered.*

Credit Card Information

Cardholder's Name: _____ ***Billing Zip Code:*** _____

Credit Card Number: _____ ***Expiration Date:*** _____

Security Code (CVV): _____ *(please note AMEX is 4 digit code on front of card.)* ***Card Type:*** _____