



PRE-AUTHORIZED PAYMENT FORM

Practice Name: _____

Doctor's name: _____

Telephone: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Credit Card

I authorize 2thPix Dental Lab to debit my credit card with the amount due as shown on my monthly 2thPix Dental Lab statement.

Charge card on the

- ☐ 10th of each month
- ☐ 20th of each month
- ☐ ____ of each month

Card Holder's name: _____

Credit Card Number: _____

Expiry Date: _____ CVV: _____

Card Holder's Signature: _____ Date: _____

The information provided on this form will be kept confidential and used only for the purpose of processing clinic payments. Your information will be handled securely and accessed only as necessary.