DENTAL Services

Providing all services for the Dental Professional

Credit Card Authorization Form

Name on Card: _____

Type of Card: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Card Account Number _____
Expiration Date _____
Security (CVV) Code _____
Billing Address _____
City, State, Zip _____
Billing Phone Number _____

Please initial next to each statement, indicate your agreement and acceptance of each condition.

_____ I authorize DENTAL SERVICES to charge the card provided above for payment for invoices.
_____ I authorize DENTAL SERVICES to keep this account information on file for future use-with consent.
_____ I acknowledge that it is my responsibility to notify DENTAL SERVICES if there are any changes to this account, or if I do not want to use this account for purchases.

_____I acknowledge that there will be a 4% fee added to each invoice total.

AUTO-PAY ENROLLMENT OPTION

_____I would like to enroll in Auto-pay. This will authorize DENTAL SERVICES to charge the card (provided above) for open invoices, without individual consent for each invoice.

_____ I am declining the Auto-Pay enrollment at this time.

Please provide an e-mail address to send receipts and invoices: _____

Signed:_____ Date: _____

Print Name: _____ Title_____

Please return this form to LFDentalServicesNV@gmail.com
or send a picture to (702) 274-0088