Dental Services New Customer Registration

In order to establish an account with Dental Services, please complete this application and send it back to us via email: LFDentalServicesNV@gmail.com or text: (702) 274-0088

Company Information

Registered Company Name: _____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Billing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email: _____

Shipping Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Accounts Payable Information

Contact Person: _____ Title: _____

Phone: _____ Email address: _____

** For Tax exempt status, please submit a valid Tax exempt certificate.

Payment Terms

- All customers are required to provide either banking account information or credit card information for Dental Services to keep on file. Dental Services will not draft funds or charge this card without permission, unless invoices remain unpaid (see below).
- There will be a processing fee of 3% of the invoice total added to all invoices paid with a credit card. We accept Visa, Mastercard, Discover and American Express. There is no fee for checks or e-checks. Wiring information can be sent upon request, and a fee may apply.
- Dental Services operates on "due upon receipt" terms. A late fee of 2% of the invoice total will apply for any invoices not paid after (5) business days. If an invoice remains unpaid after (7) business days, Dental Services will either draft from the bank account or charge the credit card on file for the total balance due, plus the 2% late fee.
- Any parts over $250.00 must be paid in advance.
- Customer is responsible for all banking fees in the event of a returned/bounced check or charge reversal.
- If you have any questions concerns regarding our payment terms, or would like to request alternate payment arrangements please e-mail LFDentalServicesNV@gmail.com.

By signing below, I acknowledge and agree to the terms above.

_____ _____

Signature Date

_____ _____

Printed Name Title/Position

DENTAL Services

Providing all services for the Dental Professional

Bank Account Withdrawal Authorization Form

Name On The Account: _____

Type of Account (please circle one):

Business Checking Business Saving Personal Checking Personal Savings

Routing Number: _____ Account Number: _____
Billing Address: _____
City:_____ State:_____ Zip Code: _____
Billing Phone Number:_____

Please initial next to each statement, indicating your agreement and acceptance of each term.

_____ I authorize DENTAL SERVICES to withdraw funds from the account provided above as 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 payments.

AUTO-PAY ENROLLMENT OPTION

_____I would like to enroll in Auto-pay. This will authorize DENTAL SERVICES to withdraw funds from the account (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 via text to (702) 274-0088

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 3% 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