KING
DENTAL LAB

CREDIT CARD / ACH PAYMENT AUTHORIZATION

Check One (1) and Enter Your Details

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 - **Recurring Charge** - You authorize regularly scheduled charges to your credit card or bank account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card or bank statement. You agree that no prior notification will be provided.

I, _____, authorize _____ to charge my

        (Full Name)   (Merchant's Name)

Credit Card below for the billed statement amount on the 1st

of each month.

This payment is for Lab Services.

 (Description of Goods/Services)

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 - **One (1) Time Charge** – Sign and complete this form to authorize the merchant below to make a one-time charge to your credit card or bank account listed below.

By signing this form, you give us permission to debit your account for the billed statement amount if payment is not received by the 15th of the month. This will only apply if payment is not otherwise received in the form of check, cash, ACH or Zelle.

I, _____, authorize _____ to charge my

        (Full Name)   (Merchant's Name)

credit card or bank account indicated below for the billed statement amount on the 15th of the month if payment is not otherwise received.

This payment is for Lab Services.

  (Description of Goods/Services)

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Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Credit Card

Visa	MasterCard	
Amex	Discover	
Cardholder Name		
_____		
Account Number		
_____		
Exp. Date _____ / _____		
CVV _____		

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the merchant in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that there is a 3.5 % processing fee applied to all credit card transactions. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

AUTHORIZED SIGNATURE _____ DATE _____

PRINT NAME _____