Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Lab Name: _____

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

I authorize Compartis Dental to charge the credit card provided herein. I agree to pay for all purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

Compartis Dental

140 S. Main Street – Manchester, PA 17345 • ph: 866-265-8440 • fx: 717-326-1165 • info@compartisdental.com