Payment by Credit Card

Cardholder Name:_____

Billing Street Address:_____

State:_____

Zip Code:_____

e.mail Address:_____

Credit Card Type:
Visa
MasterCard
American Express
Discover

Credit Card Number:_____

Expiration Date:_____

Security code:_____

I authorize Inter-Chrome Dental Laboratory to charge the current statement balance to the credit card indicated above for the total amount due each month. I also authorize charges for any additional related service that I may incur. Charges to my account may vary.

I understand that I may cancel my recurring charge upon written notice to Inter-Chrome Dental Laboratory allowing thirty days (30) time for action on my cancellation notice.

Card Holder Signature:_____

Date:_____

Please complete and fax to Lisa at 757-271-3053 OR
email to lisa@interchromedental.com