



CRAFTSMANSHIP | TECHNOLOGY | RELATIONSHIPS

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**