

DentalArtCenters.com
(800) 996-0188

Credit Card Authorization

I, _____ (Name of Credit Card Holder) authorize

DentalArtCenters.com

to process a credit card payment in the amount of

\$1,200 for a 6-month period of patient referral services rendered (a Savings of \$300).

OR

\$250 each month for 6 months for patient referral services rendered in a 6-month period.

Dentist Name _____ Date _____

Practice address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____

Please charge my (Check one)

VISA MC AMEX

Card Number _____ Exp. Date _____
(Print clearly)

Name as it appears on the Card _____

(Credit card billing address, if different than practice address)

Signature of Dentist

Date

Signature of Credit Card Holder (if different than Dentist)

Date

PLEASE FAX COMPLETED FORM TO (888) 492-2900.