Aesthetic Oral Arts

1106 West Park Street, Suite 10 | Livingston, MT 59047 | 406-222-5944
office@aoalabs.com | www.aoalabs.com

Recurring Credit Card Payment Authorization

This signed letter gives Aesthetic Oral Arts Dental Laboratory authorization to charge your credit card that is currently on file in their office. Charges are for month end statements. A copy of the statement and credit card receipt will be sent to the doctor via fax when monthly charge occurs. Credit card information is kept confidential.

I _____ authorize Aesthetic Oral Arts to charge my credit card indicated below for
(Cardholder's Name) (Merchant's Name)
the full amount due each billing period (monthly).

Billing Information

Billing Address _____ Phone #_____

City, State, Zip _____ Email _____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

Credit Card Number _____

Expiration Date _____

CVV _____

Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Aesthetic Oral Arts Laboratory with any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above mentioned payment dates falls on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of the credit card transaction to my account must comply with the provisions of the U.S. law. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions, as long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE (Cardholder) _____ DATE _____