Levson Dental Lab
Credit Card Authorization Form

By completing and signing this form, you authorize Levson Dental Lab to charge your credit card on a monthly basis for services rendered. Payments will be processed on the 15th of each month or the following business day, if the 15th falls on a weekend or holiday.

Customer Information:

- Practice Name: _____
- Doctor's Name: _____
- Billing Address: _____
- Phone Number: _____
- Email Address: _____

Payment Information:

- Cardholder's Name: _____
- Credit Card Type:
  - ☐ Visa
  - ☐ MasterCard
  - ☐ American Express
  - ☐ Discover
- Credit Card Number: _____
- Expiration Date (MM/YY): _____
- CVV (Security Code): _____
- Billing Zip Code: _____

Authorization Agreement:

I authorize Levson Dental Lab to charge my credit card for services rendered on the 15th of each month or the following business day, if the 15th falls on a weekend or holiday. I understand that this authorization will remain in effect until I provide written notice to terminate this agreement. I agree to notify Levson Dental Lab in writing of any changes to my payment method or account information at least 10 business days before the next billing date.

I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company, provided the transactions correspond to the terms indicated in this authorization form.

Cardholder's Signature: _____

Date: _____