Credit Card Authorization Form

Please print and complete this credit card authorization form. You may return it with your next case or you can fax the form with *only* your signature to (888) 288-8884. For security purposes, we will help you fill out the form once we receive the fax. All information remains confidential. You may cancel this authorization at any time by request.

Name on Card: _____

Billing Zip Code: _____

Credit Card Type: ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: (last 3 digits on the back of the credit card) _____

Amount to Charge: $_____ or ☐ Entire Statement

Are you enrolled in the autopay program? ____Yes ____No

(If yes) I would like Resilient Smiles to charge my card every (choose between 1st-10th) _____ of every month.

I authorize Resilient Smiles Dental Lab to charge the amount listed above to the credit card provided herein. I agree to pay for the purchases made in accordance with the issuing bank cardholder agreement. I understand that this card will be kept on file for future transactions regarding my account.

Signature: _____ Date: _____