Classic Craft Dental Laboratory
Payment Agreement and Credit Card Authorization Form

___ I prefer to pay Classic Craft Dental Lab by the 15th of the month with a **check** or **money order**. But if my bill with Classic Craft is not paid by the due date then I hereby authorize Classic Craft Dental Laboratory to charge my American Express, Visa or Master Card (including "Debit Cards) for services they render to me. I understand that my monthly credit card or bank statement will reflect these charges.

___ I prefer to pay Classic Craft Dental Lab by the 15th of the month with my **American Express**, **Visa, Discover** or **Mastercard** (including "Debit"Cards) for services they render to me. I understand that my monthly credit card or bank statement will reflect these charges.

Dr's Name ____________________ Office Name ______________________

Address ____

City ______________________ State ________ Zip ________________

Phone # ______________________ Fax # ___________________________

E-mail ____

Credit Card Type Visa_____Mastercard _____ Amex _____ Discover ____

Name on Card ____

Credit Card # ____

Expiration Date ________________ Security Code (3 or 4 digits) ________

Authorized Signature____

Please notify Accounts Receivable if there is a specific day of the month other than the 15th that you would like for us process your payment.

Accounts Receivable (912) 355-1100