Credit Card Billing Authorization Form

Credit Card Billing Information	
Account Name:	
Account Number:	**M**
Person Authorizing:	
Credit Card Type:	☐ Visa ☐ Mastercard ☐ AMEX
Credit Card Number:	
CVC Number: (# on back of card for VS/MC and front for AMEX)	
Expiration Date:	
Name as it appears on card:	
Billing Address:	
City:	
State/Province:	
Zip/Postal Code:	
Phone Number:	
Fax Number:	
Email:	

Please select one of the following payment options:	Initial
Bill my credit card once per month for the amount of service provided each month for all contracts with Maverick Dental Laboratories on the: ☐ 1st ☐ 15th ☐ 20th	

Applicant agrees that all information provided is accurate and complete. Applicant also acknowledges that all orders may be immediately terminated at Maverick Dental Laboratories discretion if any charges are declined or charge backs are claimed against any outstanding invoiced amount. Disputes to amounts invoiced should immediately be reported to accountsreceivable@maverickdental.com.

Change in status of this card can also be reported to accountsreceivable@maverickdental.com or 866-294-7444 ext 115.

The undersigned is the duly authorized representative for the above named company.

Authorized Signature:______________________________ **Date:**________________

THREE WAYS TO SUBMIT:

1.) Digitally fill out, sign and email completed form to: accountsreceivable@maverickdental.com
2.) Digitally fill out, sign, print and scan or fax completed form to: accountsreceivable@maverickdental.com or 724-519-8012
3.) Print, fill out, sign and scan or fax completed form to: accountsreceivable@maverickdental.com or 724-519-8012