Credit Card Authorization for In-House Savings Plan

I, _____, authorize Colony Dental, PLLC to charge my debit/credit card indicated below for $_____ **one time** or **annually** on renew date *(PLEASE CIRICLE ONE)* for payment for my participation in the In-House Dental Savings Plan.

Card Type: VISA MASTERCARD AMEX DISCOVER

(PLEASE CIRICLE ONE)

Card Holder's Name:_____

Account number:_____

Expiration Date:_____ **CVV:**_____

Billing Zip Code associated with card:_____

I authorize Colony Dental, PLLC to charge the credit card indicated in this authorization. I understand that this authorization will remain in effect until I request termination in writing. If the above noted payment date falls on a weekend or holiday, I understand that the payments will be executed on the next business day. I certify that I am an authorized user of the above credit card and that I will not dispute the payment with my credit card company; provided that the transactions correspond with the terms indicated on this form. I also understand that if at any time my credit/debit card number or expiration date changes that it is my responsibility to contact Colony Dental immediately to update this information.

Signature:_____ **Date:**_____

COLONY DENTAL
Family & Cosmetic Dentistry

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