CREDIT CARD SIGNATURE ON FILE AUTHORIZATION

edmonds
DENTAL PROSTHETICS

→ EdmondsDentalProsthetics.com

2065 W. Woodland
Springfield, MO 65807

1.800.462.3569
FAX: 417.881.0484

This form is used for the authorization of credit card payments. The information collected on this form will be used by Edmonds Dental Prosthetics to electronically transmit credit card payments to Edmonds' financial institution. **Beginning April 1, 2024. Edmonds will charge a 3% processing fee on all credit card payments.**

Laboratory fees will be charged at the end of each month. Invoices and end-of-month statements are accessible through the Edmonds Doctor Portal on our website.

Please Complete This Form in Its Entirety and Return It to Edmonds Dental Prosthetics

Doctor: _____

Practice Name: _____

License Number: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Accounting Contact: _____

Accounting Phone: _____

Accounting Email: _____

PLEASE PRINT A COPY FOR YOUR RECORDS

☐ **VISA** ☐ **MASTERCARD** ☐ **AMEX** ☐ **DISCOVER**

Card #: _____

Expiration Date: ____/____ **CVV Code:** _____

I, the undersigned, authorize Edmonds Dental Prosthetics to keep my credit card information on file, and pay my monthly laboratory fees from this account.

_____
Account Holder Signature

_____
Print Name Date