BIOCAD
Dental Laboratories Ltd.

PRE-AUTHORIZED PAYMENT FORM

Please send over a completed copy.

Practice Name: _____

Doctor's name: _____

Telephone: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Credit Card

I authorize BIOCAD Dental to debit my credit card with the amount due on shown on my monthly BIOCAD Dental statement.

Charge card on the ○ **10th** of each month
○ **20th**
○ _____

VISA

Card Holder's name: _____

Credit Card Number: _____

Expiry Date: _____ CVV: _____

Card Holder's Signature: _____

Date Signed: _____