Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us by email or phone. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____ , authorize Integrity Dental Services to charge my credit card above for the full previous month's statement by the last working day of the month. I understand that my information will be saved to file for future transactions on my account. If you decide to pay, please have the form submitted before the 25th of the month.

_____ _____

Customer Signature Date