BIOCAD Dental Laboratory
Payment Agreement and Credit Card Authorization Form

☐ I prefer to pay BIOCAD Dental Lab by the 15th of the month with a **check** or **bankdraft**. But if my bill with BIOCAD is not paid by the due date then I hereby authorize BIOCAD Dental Laboratory to charge my **VISA card** for services they render to me. I understand that my monthly credit card or bank statement will reflect these charges.

☐ I prefer to pay BIOCAD Dental Lab by the 15th of the month with my **VISA card** for services they render to me. I understand that my monthly credit card or bank statement will reflect these charges.

Dr's Name _____ Office Name _____

Address _____

City _____ Province _____ Postal Code_____

Phone # _____ Fax # _____

E-mail _____

VISA Card # _____

Name on Card _____

Expiration Date (mm/yy) _____ Security Code (3 or 4 digits) _____

Authorized Signature_____

Please notify Accounts Receivable if there is a specific day of the month other than the 15th that you would like for us process your payment.

Accounts Receivable (604) 270-2230