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Cottonwood ORTHODONTIC LAB

6526 South State Street
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Credit Card Authorization Form

Please send a copy with your first case

Doctor: _____

Credit card#: _____

Expiration date: _____

Security code: _____

Name on card: _____

Billing address: _____

_____

City:_____ State:_____ Zip:_____

One time charge for amount of: _____.___

Keep card# on file. ☐

Automatically charge each month. ☐

Wait for Doctor's OK to charge. ☐

Doctors signature: _____ Date: _____

Authorized over the phone by: _____ Date: _____

"We'll make it Right"