# Hatzakortzian Dental Lab

1345 N. Fitzgerald Ave. Unit F
Rialto, CA 92376
888-345-0173

## Recurring Payment Authorization Form

Schedule your payment to be automatically deducted from your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

**Recurring Payments Will Make Your Life Easier:**

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

**Here's How Recurring Payments Work:**
You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your credit card statement as "Hatzakortzian Dental Lab Inc." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

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**Please complete the information below:**

I _____ authorize Hatzakortzian Dental Lab to charge my credit card
(full name)

indicated below for lab fees incurred for the prior month on the 1st Business day of each month

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

**Credit Card**

Visa MasterCard

Amex Discover

Cardholder Name _____

Account Number _____

Exp. Date _____/_____

CVV (3 digit number on back of card, 4 digit on the front for Amex) _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Hatzakortzian Dental Lab in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Hatzakortzian Dental lab may at its discretion attempt to process the charge again within 30 days, and agree to an additional $35 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

**Email Back to Saro@HDentallab.com or FAX 909-562-0999**