

Authorization for the use of visa and Mastercard

We are making your accounting simpler!

This authorizes Talisman Dental Lab Inc. to make automatic withdrawals from my VISA or MasterCard account every second week of every month. The amount withdrawn will be equal to the amount owed to Talisman Dental Lab Inc. for the previous month and any outstanding charges.

YOUR NAME _____
(Please Print)

NAME as it appears on the card _____
(Please Print)

CARD _____ VISA _____ MasterCard _____
(Circle One Please)

CARD NUMBER _____

EXPIRY DATE _____

SIGNATURE _____

DATE _____