MagellanDentalArts

CREDIT CARD AUTHORIZATION

NAME ON CARD: _____

ADDRESS: _____

_____

PHONE NUMBER: _____

I AUTHORIZE MAGELLAN DENTAL ARTS CANADA INC. TO PROCESS PAYMENTS AGAINST MY CREDIT CARD NUMBER:

☐ VISA ☐ MasterCard

CARD NUBER: _____

EXPIRATION DATE: ___/___

_____
(signature)

_____
(date)

This authorization is to be kept on record to apply credit card payments to all invoices related to the business indicated above (unless otherwise specified).

Please email the form to ali@magellandental.com or fax to 604-630-7063.