



MDS Miami Dental Supplies™

4714 SW 74 Avenue Miami FL 33155
Tel: 305-267-4545 Fax: 305-267-4565

miamidental@aol.com www.miamidentalsupplies.com

One Time Credit Card Payment Authorization Form

Sign and complete this form to authorize MDS Miami Dental Supplies to make a one time debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I \_\_\_\_\_ authorize MDS Miami Dental Supplies Corp to charge my credit card (full name)

account indicated below for \_\_\_\_\_ on or after \_\_\_\_\_. This payment is for (amount) (date)

\_\_\_\_\_. Invoice # \_\_\_\_\_. PO# \_\_\_\_\_ (description of goods/services)

Company Name \_\_\_\_\_ Resale Certificate# \_\_\_\_\_

Billing Address \_\_\_\_\_ Phone# \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

Account Type: [ ] Visa [ ] MasterCard [ ] AMEX [ ] Discover
Cardholder Name \_\_\_\_\_
Account Number \_\_\_\_\_
Expiration Date \_\_\_\_\_
CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.