Central California Dental Academy Payment Authorization Form

Name of Student: ______________________________________ **Date:** ________________

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SIGN AND COMPLETE THIS FORM TO AUTHORIZE CENTRAL CALIFORNIA DENTAL ACADEMY TO MAKE A ONE TIME DEBIT TO YOUR CREDIT CARD LISTED BELOW.

BY SIGNING THIS FORM, YOU GIVE CENTRAL CALIFORNIA DENTAL ACADEMY PERMISSION TO DEBIT YOUR ACCOUNT ON OR AFTER THE INDCATED DATE. FOR THE AMOUNT SPECIFIED IN YOUR CONTRACT AGREEMENT. THIS IS A SINGLE TRANSACTION ONLY AND DOES NOT PROVIDE AUTHERIZATION FOR ANY ADDITIONAL UNRELATED TRANSACTIONS. PLEASE COMPLETE THE INFORMATION BELOW:

Payment Method: ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex

Cardholders Name: ____

Credit Card Number: ____

Billing Address: ____

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Expiration Date: _____________ **Sec Code (3 or 4-digit number on the back of card):** _____________

Phone number: (_____)-______________________**E-mail:** ___________________________________

Payment Amount: $________________

Cardholder's Signature (required for all purchases) ____

IF PAYING BY CHECK, ATTACH AND MAIL TO:

PLEASE MAKE CHECK PAYABLE TO

Central California Dental Academy

Central California Dental Academy

P.O. Box 5793

Bakersfield, CA.93388

Card Holder's Signature ____