New Horizons Dental Laboratory
7270 W. 118th Place Unit D
Broomfield CO 80020

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# Account Establishment Form / Credit Card Signature on File Contract

All information will remain confidential

It is the policy of New Horizons Dental Laboratory to invoice each procedure throughout the month. On the 1st of each month each account will receive a statement reflecting all invoices from the previous month. We kindly request that each client pay the balance owed on their account (preferably by check or ACH) by the 15th of the month.

If payment has not been received by the 15th of the month due, then the client agrees and authorizes New Horizons Dental Laboratory to have the entire balance owed, to be charged to the credit card on file.

We accept Visa and Master Card.

All credit card information is kept secure and strictly confidential

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I, the undersigned, understand that this authorization is valid from the date signed below unless I cancel the authorization with written notice. I also agree to contact New Horizons Dental Laboratory in case of any change to my credit card information.

Name on Card: ________________________________________

Billing Address: ________________________________________

________________________________________

Credit Card Type: _____ Visa _____ Mastercard

Credit Card Number: ________________________________________

Expiration Date: ________________________________________

Card Identification Number: ______ (last 3 digits located on the back of the credit card)

I authorize _________________________ to charge the amount agreed on the statement received, to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: ________________________________________

Date: ________________________________________

Print Name: ________________________________________

**Return the completed and signed form to New Horizons Dental Laboratory at your earliest convenience.**