Dental Practice Services, Inc.

CREDIT CARD FORM

Individual Application: Complete the following information for credit card or debit card withdrawal authorization and attach with application. Both the application and withdraw authorization must be signed.

Member Payee Information:

LAST NAME	FIRST NAME	MI	DATE OF APPLICATION
DENTIST NAME/PRACTICE NAME			EFFECTIVE DATE
PLAN TYPE	COVERAGE TYPE (S, C, F)	MONTHLY WITHDRAWAL AMOUNT	DATE OF 1ST WITHDRAWAL

Credit Card Information: **Authorization for Pre-Arranged Payments**

CREDIT CARD:

- ☐ VISA
- ☐ MASTERCARD
- ☐ DISCOVER

Card # _____

Expiration Date _____ 3-Digit "V" #_____

Billing ZIP Code_____

Name on Card (if different)_____
(Print Legibly)

There is a $3.00 service charge for every credit card debit, payable in addition to the monthly membership fee

I hereby request and authorize Dental Practice Services, Inc. (DPS) to deduct a monthly membership fee from my credit card account with the financial institution named above on the 5th of each month or the first business day thereafter. This authority shall remain in effect for the minimum twelve-month period and thereafter until revoked by me in writing and until said notice is actually received. I agree that DPS shall be under no liability whatsoever upon processing these payments in accordance with the terms.

X _____

Applicant Signature Date