Alabama Dental Association

836 Washington Street
Montgomery, AL 36104
334-265-1684

Ski and Learn Seminar, Big Sky, Montana
March 13 – March 20, 2019

Credit Card Payment Authorization Form

I, ____, authorize Alabama Dental Association
(Full name)

To charge my credit card account indicated below for _________________ on or after
(Amount)

___________________. This payment is for _____________________________________.
(Date) (Description of Service)

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX

Cardholder Name: ____

Business Name: ____

Account Number: ____

Security Code: ____

Expiration Date: ______________________ Amount: _______________________

Cardholder Name: ____

Billing Address: ____

City: ______________________________ State: ____________ Zip: ____________

Phone: (_____) ______-_________ Email: _________________________________

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.