www.arklign.com
info@arklign.com
tel: 800.361.1659
fax: 408.273.6696
2526 Qume Dr., Ste. 15, San Jose, CA 95131

EasyPay Automatic Payment Agreement (Optional)

Dental Practice Name: ______________________________

Cardholder Name (As it appears on card): ______________________________

Billing Address (Street, Suite No.): ______________________________

(City, State, Zip): ______________________________

Billing Phone: ____________ Card Number: ____________________ Expiration Date: ________

Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Verification Code (4-digit number on the front of Amex or 3-digit number on the back of other cards): ____________

I HEREBY AUTHORIZE ARKLIGN LABORATORIES TO CHARGE MY CREDIT CARD LISTED ABOVE TO PAY MY ARKLIGN LABORATORIES BILLS. I UNDERSTAND THAT AUTOMATIC PAYMENTS MAY BE CANCELLED IF I NOTIFY ARKLIGN LABORATORIES IN WRITING PRIOR TO THE NEXT BILLING DATE.

Cardholder/Authorization Signature (Faxed signature will serve as original): ____________________ Date: ____________