CARROLL
DENTAL LABORATORY, INC.

PRE-AUTHORIZATION CREDIT CARD APPROVAL AGREEMENT

Cardholder's Name: ____

Practice Address: ____

City: ________________________________ State: ________ ZIP: _______________

Phone: (   ) ______________________________ Fax: (   ) ___________________

Credit Card Billing Address: ____

City: ________________________________ State: _________ ZIP: ______________

Phone: (   ) ______________________________ Fax: (   ) __________________

E-Mail Address (*required*): ____

VISA/MasterCard/AMEX #:____

Expiration Date: ______________ CVV Code (3-digit code on back of card):________

This Agreement is between the Cardholder (above) and ***Carroll Dental Laboratory, Inc***. The Agreement shall become effective upon signature of Cardholder. I hereby certify that the information provided on the Agreement is true, correct and complete as of the date indicated below. I agree to promptly notify ***Carroll Dental Laboratory, Inc***. of any changes in the information provided.

I hereby authorize ***Carroll Dental Laboratory, Inc.*** to charge my credit card for work completed as indicated above on the 1st of each month (or the following business day). This Pre-Authorization shall remain in effect until I notify ***Carroll Dental Laboratory, Inc***. in writing of its cancellation.

____   _______________________

Cardholder's Signature   Date

Please complete and return to Dianna Carroll by fax (252-522-4612) or e-mail (cdl-dianna@suddenlinkmail.com). Thank you!