Alabama Dental Association

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

Ski and Learn Seminar, Big Sky, Montana
March 14 – March 21, 2018

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.