LICENSE VERIFICATION

We are required to have the license number of the prescribing dentist on file or included on every prescription submitted to the laboratory. By signing this form, you verify that all prescriptions submitted to the lab have been completed/ authorized by the prescribing dentist, and that you agree to the terms & conditions located on our website.

PRESCRIBING DENTIST NAME:

_____

LICENSE NUMBER:

_____

STATE:

_____

NPI:

_____

SIGNATURE:

_____

BILLING STATEMENT DELIVERY:

☑ All statements will be delivered electrically to the billing email

AUTOPAY & CC AUTHORIZATION:

- ☐ Run credit card for each invoice
- ☐ Run credit card on last business day of each month
- ☐ Run credit card at the end of each week

I AUTHORIZE REGULARLY SCHEDULED CHARGES TO MY CARD PER THE "AUTO-PAY OPTION" SELECTION ABOVE. I UNDERSTAND I WILL BE CHARGED THE FULL INVOICE OR STATEMENT BALANCE, DEPENDING ON THAT SELECTION, AND THAT THE CREDIT CARD CHARGE WILL APPEAR ON MY CREDIT CARD STATEMENT.

Invoices will be sent with each case and statements will be sent at the beginning of each month, reflecting the previous months invoices. A 2% per month late fee will be added to each outstanding balance exceeding 30 days. Past due accounts are subject to C.O.D.

_____

SIGNATURE OF CARD HOLDER: DATE:

PHONE: 949-899-9010 | WEB: EBDLAB.COM
17475 Gillette Ave., Suite 120, Irvine, CA 92614

CREDIT CARD INFORMATION

BILLING CONTACT INFORMATION

BILLING CONTACT:

BILLING EMAIL:

BILLING PHONE:

CREDIT CARD INFORMATION:

☐ Master Card ☐ Visa ☐ American Express

NAME ON CARD:

BILLING ADDRESS:

CARD NUMBER:

EXPIRATION DATE: SECURITY CODE:

*EBD will destroy this document after the credit card information has been stored securely in our PCI compliant software.

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