Credit Card Authorization

American Association of Public Health Dentistry
136 Everett Road, Albany NY 12205
518-694-5525 (Phone)

To Our Valued Customers:

Visa, MasterCard, and Discover have recently changed their procedures for processing credit cards over the telephone and by mail. To ensure that we are in compliance we must have this receipt signed, authorizing use of your credit card for purchases. We must be able to produce this document when requested by the processor. Your personal, identifiable, information will be kept confidential and stored in a secure environment.

If you have any questions, please do not hesitate to call us at 518-694-5525

Thank you for your continued trust and confidence - We appreciate your business

Cardholder Company/Organization Name: ____

Cardholder Company/Organization Contact:
____

Cardholder Company/Organization Phone Number:
____

I, _____________________________ , allow the following total balance charged to our credit card:

Authorized Signature: ____

Total Charged: $____________

Email (for receipt): ______________________________________

Credit Card Information

Card Type (Circle One):

Card Number: __ __ __ __- __ __ __ __- __ __ __ __- __ __ __ __

Expiration Date: __ __ / __ __ (MM/YY)

CVV2#: __ __ __ (last three digits in the signature line on the back of the credit card)

Name (On Card): ____

Address (relating to card owner): ____

City / State / Zip: ____

Phone: _____________________________________

Please fax form to Marti Simmons c/o AAPHD at 518-694-5525