



**Get started with Easy Pay Service! Please complete and fax to
630-323-2163 or mail to the address below.**

Credit Card Type: **Visa** or **MasterCard**

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ V-Code: _____
(The last three digits on the back of the card)

Name on Card: _____

Billing Address for Card: _____

Preferred billing date: _____

I authorize Sequoia Dental Studio to process payment to the credit card listed above between the 5 and 10th of each month, for my statement balance and I may cancel the automatic monthly billing at any time. I understand the use of my credit card will not be charged for any other purpose.

Signature: _____ Date: _____
(Credit card holder)

414 Plaza Drive, Unit 207 Westmont, IL 60559

Email: info@labsequoia.com

Visit us at www.labsequoia.com