

# Application

## For Open Account Status

Business Name \_\_\_\_\_

Name of Owner \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Aesthetic Designs Laboratory requires a credit card on file to establish an open account. The credit card will be charged the entire current month's balance on the first business day of the following month (example: January's charges will be billed to the credit card on February 1<sup>st</sup>).

We accept Visa or MasterCard. By giving us your credit card information the cardholder agrees to be personally responsible and liable for all debt incurred at Aesthetic Designs Laboratory. The cardholder also agrees to allow Aesthetic Designs Laboratory to conduct a credit check.

Visa  MasterCard Credit Card Number \_\_\_\_\_

Card Expiration Date \_\_\_\_\_ Verification Code \_\_\_\_\_

Name That Appears on Card \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I hereby certify the information provided is true, correct and complete as of the date indicated below. I agree to promptly notify Aesthetic Designs Laboratory of any future changes in this information.

I authorize Aesthetic Designs Laboratory to charge my credit card upon completion of each order filled.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Infection Control Disclaimer

My signature below confirms that our facility is in compliance with the infection control procedures required by the dental profession. Every case component has been disinfected prior to being sent to Aesthetic Designs Laboratory for processing.

Name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_