

# Card authorization form

I, \_\_\_\_\_, give permission to Kansas Dental Association to charge  
**Buyer name** **Business name**

my card for the following purchases. My card details will be stored in my profile and will only be used for approved purchases.

\_\_\_\_\_  
**Amount authorized**

\_\_\_\_\_  
**Cardholder email**

\_\_\_\_\_  
**Product/service** i.e. Web Ad, JKDA Ad Billing

*All fields required*

**Wed Ad Duration Date:** \_\_\_\_\_ to \_\_\_\_\_  
(MM/DD/YYYY)

## Card information

### Card type

- MasterCard
- Discover
- VISA
- AMEX
- \_\_\_\_\_
- Other

\_\_\_\_\_  
**Cardholder** (Name on card)

\_\_\_\_\_  
**Card number**

\_\_\_\_\_  
**Expiration date**  
(MM/YYYY)

\_\_\_\_\_  
**ZIP code**  
(From credit card billing address)

## Recurring payments information

### Charge every:

Week   Month   Quarter   Other \_\_\_\_\_

**Charge on this date** \_\_\_\_\_  
(For example, the 1st of every month)

\_\_\_\_\_  
**Payment amount**

\_\_\_\_\_  
**Product/service sold**

**Email receipts**

**Mail receipts to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To cancel, contact: [Sandra Romero at sandra@ksdental.org](mailto:sandra@ksdental.org)  
(Name and email)

**Cancellations must be received 1 week prior to the new billing date, fill out a new card authorization form for each ad**

### Terms of agreement

(For example, cancellations must be received 1 week prior to expected billing date)

\_\_\_\_\_  
**Customer signature**

\_\_\_\_\_  
**Date**