

CREDIT CARD AUTHORIZATION AND CONSENT FORM

I, _____
hereby authorize TRI® Dental Implants Int. AG to charge my credit card for orders respective invoices for products, shipping costs, etc...

Type of Card Visa MasterCard

Credit Card Number: _____

Expiration Date: _____

Name of Cardholder: _____

Credit Card billing address: _____

CVC (3/4 digit security code on signature strip): _____

Authorized Signature of Cardholder: _____

Signing this, I acknowledge the charges described hereon and assume full responsibility for said charges and agree to honour and abide by the terms of payment.

I acknowledge and accept TRI® Dental Implants Int. AG [terms and conditions](#)

Place, date

Practice stamp/ Signature

Please send the completed & signed form to the address mentioned below or via fax to +41 32 510 1601