



American Association of Orthodontists Foundation

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I choose:

___ Option One, i.e., having the AAOF bill my credit card according to my payment schedule

___ Option Two, i.e., completing my pledge by making one credit card payment

Date: _____

Your signature: _____

AUTOMATIC BILLING AUTHORIZATION FORM

Member Name: _____ ID Number: _____

FROM CREDIT CARD:

I authorize you to charge my bill directly to the credit card(s) listed below:

Primary Card Account

Secondary Card Account

Name on credit card (exactly as printed)

Name on credit card (exactly as printed)

Billing Address for credit card (Street, Apt.#)

Billing Address for credit card (Street, Apt. #)

City, State Zip

City, State Zip

Credit card Number Expiration Date

Credit card number Expiration Date

Signature Today's Date

Signature Today's Date

Bill all charges to the above card(s). Since the payment amount may vary, I will receive written notification of the amount and date of the next charge prior to each scheduled transaction date.

This authorization is valid until I provide you with written cancellation.