HERMITAGE DENTAL LAB

Auto Pay Request

Date: _____

Practice Name: _____

I authorize Hermitage Dental Lab to charge the following credit card
_____-_____-_____-_____
Name on Card: _____
Expiration Date: _____
Cvv/Cid # _____
Billing Zip Code: _____

Is billing address the same as practice? YES or NO
If No please complete:
Address: _____
_____

Please choose which day for autopay setup **(5th) (10th) (20TH)** *Please circle one option.*

Signature: _____

**If you need to make a change please call us to update info or cancel autopay.*

Please mail form to:
Hermitage Dental Lab
237 Jackson Meadows Dr.
Hermitage, TN 37076

or email to:
Accounting Email: Jennifer@hermitagelab.com