1145 Camden Avenue
PO Box 11627
Rock Hill, South Carolina 29731
Toll Free (800) 845-1116
Local (803) 324-4040
www.shererdentallab.com

Big lab capabilities. Small lab service.

Credit Policy

We offer you the convenience of a monthly open account after a credit check. Credit reference form on the back must be completed. Invoices are sent with each case and statements are mailed the first of each month which totals the previous month's invoices.

- *All statements are net due upon receipt.*
- *A 1.5% service charge will be added to unpaid balance if a payment is not received by the 15th of the month.*
- *All payments received by customers with a past due balance will be applied to service charges first and then to the oldest outstanding balance.*
- *Customers with outstanding balances of 60 days or more will be converted to a COD basis with a minimum of $100 added to each case to be applied to the outstanding balance. All COD cases will be delivered via UPS or FedEx at your cost.*
- *In the event an account must be collected by a collection agency or an attorney, the customer will pay the costs of collection.*

I (we) understand that you offer the convenience of a monthly open account after a credit check. In the event of my (our) default, I agree to pay reasonable attorneys fees and collections costs.

Signature: ____

Name: ____ Federal ID # or SS#: ________________________

Business address: ____

City: ______________________ State: __________ Zip: _____________ Phone: __________________

Fax: ______________________ Email: ____

Contact Person: ____

Home address: ____

City: ______________________ State: __________ Zip: _____________ Phone: __________________

How Would You Like To Pay?

□ Automatic Credit Card Payment (Processed on the 5th of each month)

□ Will call when charge can be applied to credit card (Due by the 15th of each month)

□ Will send check after receipt of monthly statement (Due by the 15th of each month)

If Paying By Credit Card:

Name as it appears on card: ____

Card Type: □ Visa □ Mastercard □ American Express □ Discover

Card #: ____ Exp Date ___________ V-Code ___________

Billing address: ____
(as shown on your card statement)

Billing City: ________________________________ Billing State: ____________ Billing Zip: ____________

Authorized signature: ____

Credit Reference Form: Please complete all four credit references and return

Company name/ Institution: ____

Contact name: ____

Account number: ____

Address: ____

Phone: _______________ Fax: _________________ Email:_________________________

Company name/ Institution: ____

Contact name: ____

Account number: ____

Address: ____

Phone: _______________ Fax: _________________ Email:_________________________

Company name/ Institution: ____

Contact name: ____

Account number: ____

Address: ____

Phone: _______________ Fax: _________________ Email:_________________________

Company name/ Institution: ____

Contact name: ____

Account number: ____

Address: ____

Phone: _______________ Fax: _________________ Email:_________________________

Please return this form by mail to PO Box 11627 Rock Hill, SC 29731 or by fax to 803-324-3243.