CDIMPLANT ACADEMY

CDI Cleveland Dental Institute

Payment Plan Form

To whom wanting to register for a payment plan, please complete the following:

Name: ____

Address:____

____

City:___________________________ **State:**____________________ **Zip:**___________

Email:________________________________ **Phone:**___________________________

Payment information: *(Preferred card information)*

Please charge my: ☐ Master Card ☐ Visa Card ☐ Discover ☐ American Express

Card#: ____ **Exp. Date:** ________________

Card holder's name *(If different than registrant)***:** ____________________________________

Billing address *(If different than above)***:** ____

City: ________________________________ **State:** ________________ **Zip:** __________

Signature: ____

By completing this form, you are authorizing Cleveland Dental Institute to charge payments on the following dates:

August 10th for $5,000

September 10th for $5,000

October 10th for $5,000

Thank you

Please send this form by:
Email: to l.amoud@cdiohio.org
Mail: Cleveland Dental Institute. 11201 Shaker Blvd. Suite 136. Cleveland OH. 44104
Fax: (216)721-8171

For questions:
Email: l.amoud@cdiohio.org
Phone: (440)520-0603