Credit Card
Payment Authorization Form

Account Name:

Credit Card Authorization

one time use only: ☐ (please check one)

auto-charge on due date: ☐

billing name and address:

owner/authorized officer's name on card

street

city | state | zip

check one: ☐ Visa ☐ MC ☐ AMEX

credit card #

exp. date | 3 or 4 digit cvv code

The undersigned owner/authorized officer on the account named does hereby authorize Physician Supply Company, Limited to charge the credit card, as reflected above, for the amount of each invoice/and or statement, as determined at the time of account establishment. The amount of each charge shall be reflected on the invoice/statement received from Physician Supply, unless a dispute with respect to such invoice/statement is brought to the attention of accounts receivable within 3 business days of receipt of goods. This authorization shall remain in effect until the reflected card expires, or until Physician Supply Company, Limited receives written notification (via signature required/certified mail) that this authorization has been cancelled.

x. _____
authorized signature

date

YOUR CARD WILL BE CHARGED ON THE DUE DATE OF THE INVOICE/STATEMENT

PLEASE FAX COMPLETED AUTHORIZATION FORM TO 281.991.1669