CREDIT CARD AUTHORIZATION FORM

Company Name: OPTITRIMMD

Phone:

Email:

Billing Address:

Cardholder Information

Cardholder Name:

Billing Address:

City: State: Zip:

Phone Number:

Email Address:

Credit Card Information

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Name on Card:

Card Number:

Expiration Date: /

CVV Security Code:

Billing Zip Code (if different):

All Credit Card and PayPal Transactions will be subjected to a surcharge of 3% Fee

PAYPAL: Ehtesham J Ghani MD SC

Do NOT email this completed form. It carries payment details. Return it by fax to 847.806.0464, or call +1 (630) 768-6784 to arrange a secure alternative.

Authorization

I authorize OptiTrimMD to charge the credit card listed above for authorized purchases or services provided.

Payment Authorization Type:

☐ One-Time Payment Amount Authorized: $

☐ Recurring Payments Amount: $

Frequency: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other:

Start Date:

This authorization will remain in effect until written notice is provided to cancel the authorization.

Signature

Cardholder Signature:

Printed Name:

Date:

Internal Use Only

Customer/Account #:

Authorized By:

Date Processed: