CREDIT CARD AUTHORIZATION FORM

PLEASE COMPLETE ALL FIELDS

Company Name: _____

Contact Name: _____

Contact phone number: _____

Email Address: _____

Billing address for credit card: _____

_____

CREDIT CARD INFORMATION								
Select One	VISA			MASTERCARD			AMEX	
Card Holder Name								
Card Number								
Expiration Date			Security Code			Billing Zip		

I, the certify that I am an authorized signer of the credit card detailed above. I authorize Salus Medical, LLC to use the credit card information above to pay any invoices for my account.

Printed name: _____ Signature: _____

Date: _____

2202 W. Lone Cactus Dr. Suite 15, Phoenix AZ 85027
Accounting contact Tel: 888-566-3778 EXT 105 Fax: 480-993-2129