Prime Medical Testing Inc.

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CREDIT CARD BILLING AUTHORIZATION FORM

Credit Card Billing Information:		
Company Name /or Individual Name: (As it appears on the card)		
Person Authorizing:		
Credit Card Type:	☐ Visa ☐ Mastercard ☐ Discover ☐ American Express	
Credit Card Number:		
CVC Number:		This is the 3 digit number listed on the back of the card.
Expiration Date:		
Billing Address:		
City, State, Zip:		
Phone Number:		
Fax Number:		
E-Mail:		

Please select one of the following payment options:		
☐ **Once**	Bill my credit card once for the following amount.	$
	Please apply this payment to the following invoice #.	
☐ **Monthly**	Bill my credit card at the beginning of every month for all services provided by Prime Medical Testing Inc.	

Signatory agrees that all information provided is accurate and complete. Signatory acknowledges that a convenience fee of 3% will be added to accommodate handling charges. Signatory acknowledges that all services may be immediately terminated at Prime Medical Testing Inc.'s discretion if any charges are declined or charge backs are claimed against any outstanding invoiced amount. Disputes to amounts invoiced should immediately be reported to sales@primemedicaltesting.com

Changes in the status of this card should be reported to sales@primemedicaltesting.com

Signature of Card Holder:	Date: