Pro-Tech Orthopedics
PHYSICAL SUPPORT SYSTEMS

Credit Card Authorization Form

I,_____ , authorize Pro-Tech Orthopedics to charge my Credit Card below for the balance of each and every invoice 30 days after shipping beginning on _____ (date).

Credit Card Information

☐ VISA ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder's Name _____

Credit Card Number _____

Expiration Date _____

Security Code (CVV) _____

Billing Address _____

City, State, Zip Code _____

Email Address _____

By signing this form, you give Pro-Tech Orthopedics permission to authorize charges to your credit card for the balances of each invoice on or anytime after the due date stated on each invoice. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. Invoices will be sent to you via email on the billing date and the balance will be authorized on the invoices' due date. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Signature:_____ **Date:**_____