BASIS MEDICAL

Improving Health, Wellbeing & Performance

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information				
Credit Card Type:	Master Card	VISA	Discover	AMEX
	Other			
Cardholder Name (as shown on card):				
Card Number:				
Expiration Date (mm/yy):		CVV:		
Cardholder ZIP Code (from credit card billing address):				

I, _____, authorize BASIS Medical, LLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date

I, _____, authorize BASIS Medical, LLC to charge my credit card for any recurring monthly payments agreed upon. I understand that my information will be saved to file for future transactions to my account.

_____ _____

Patient Signature Date