3B Medical
799 Overlook Drive
Winter Haven, FL 33884

Credit Card Authorization Form

Name of Company: ____

Name on Card: ____

Billing Address: ____

____

___AMEX ___ Discover ____ Mastercard ___Visa

Credit Card #:____

Expiration Date: ________________ CSV Code: ________________________

Amount to Charge: ____

(***3 % processing fee will be added to each payment***)

Invoices: ____

____

Authorized Signature: ____