Authorization Form

☐ Credit Card OR ☐ Debit Card

3% processing fee will be added to each CC payment

[ ] AMEX [ ] DISCOVER [ ] MASTERCARD [ ] VISA

Card Holder Name: _____

Company Name: _____

Billing Address: _____

_____

Credit Card Number: _____

Expiration Date: _____ CSV Code: _____

Invoice(s): _____

_____

Should _____ account go beyond payment terms, I authorize 3B Medical to charge the above card for full payment. Full payment could be a one-time payment or payment in increments at 3B Medical Inc's discretion. Any changes to this card will be communicated to 3B Medical Inc immediately with updated card information.

_____ _____

Name (Print) Authorized signature on behalf of Company Date