




CREDIT CARD AUTHORIZATION FORM

Protected when completed

Date:	Client Name:
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Address:

Telephone:
Driver's License#:

CREDIT CARD INFORMATION (Please print)	
Cardholder's Name:	Card #:
Card Type: <input type="checkbox"/> MasterCard  <input type="checkbox"/> Visa  <input type="checkbox"/> Amex 	Expiry date:
Billing Address (if different from above):	Amount to be charged: \$
	Card Present <input type="checkbox"/> Yes <input type="checkbox"/> No

I, _____ (cardholder) authorize Ability Healthcare Supplies Inc. to charge on my credit card, the sum of \$ _____ for products and services previously discussed – an invoice for which will follow. I have also read, understand and agree to the important information and conditions specified herein.

_____ **Date:**

_____ **Cardholder's signature**

PLEASE KEEP CREDIT CARD # ON FILE FOR FUTURE TRANSACTIONS
 DO NOT KEEP CREDIT CARD # ON FILE FOR FUTURE TRANSACTIONS

IMPORTANT INFORMATION AND CONDITIONS:

I agree to pay the total amount as entered above according to the card issuer agreement. I further acknowledge that I have read the terms and conditions of the sales agreement stipulated hereon. I understand and agree to these terms and expressly waive any rights to credit card charge backs as a means to mediate disputes.