Credit Card Authorization Form

All information will remain confidential

Cardholder Name: _____

Billing Address: _____

_____

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: _____

Expiration Date: Month_____ Year_____

Card Identification Number (last 3 digits located on the back of the card): _____

Amount to charge: $ 360.00

☐ By checking this box I authorize the Walesby Vision Center to charge the agreed amount listed above to my credit card provided herein. I understand that my credit card will be charged if I fail to attend my screening appointment or fail to notify the Walesby Vision Center 48 hours in advance of the appointment. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder: Please print name, sign, and date below:

Printed name: _____

Date: _____

Click Below to Submit Form!