



Authorization Form

Credit Card OR Debit Card

[] 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. Customer agrees not to dispute credit card charges.

Name (Print) Authorized signature on behalf of Company Date