Phone: 855-878-1489 Fax: 866-875-4437

Credit Card Authorization

I, _____(Name and Pharmacy Name) Authorize Healthcare & Diagnostic Solutions Inc. to process on the credit card listed below, payment for products purchased when order is placed.

(Print Clearly)

Type of Card: _____

Credit Card NO# _____

3 Digit V-Code: _____ (located on the back of the card)

Credit Card Exp. Date: _____

Billing Zip Code: _____

Business Name: _____

Authorized Signature: _____

Date: _____