



One Time Credit Card Payment Authorization Form

Sign and complete this form to authorize Onsite Hearing Care to make a one-time charge to your credit card listed below.

By signing this form you are giving your permission for a single transaction for the amount indicated below.

Please complete the information below:

I authorize Onsite Hearing Care to charge my credit card indicated below for \$_____ on or after _____ (date).

Patient Name_____

Card Holder Name_____

Email Address_____

Card Holder Address_____ Zip Code_____

Credit Card Number_____

Expiration Date_____

Security Code (on back of card)_____

Signature_____ Date_____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in this form.