CREDIT CARD/E CHECK AUTHORIZATION FORM

Patient Name: ______________________ Date: _______________

Chart #: ______________________

I authorize the charge of $ ______________ to my credit card/checking acct for the product(s) I have received from Medequip, Inc.

Please fill out the following information:

Name on Card/Account: ____________________________

Billing Address: ___________________________________

____

Patient email address:______________________________

Credit Card #: _________________________ V-code: _______ Expiration Date: ________

OR

Bank Routing #: ______________________ Account #:_________________________

Email Completed Form To: Susy@Medequiportho.com OR Fax to: (949) 487-4766

27 Brookline Aliso Viejo, CA 92656 - Tel: 949.443.4414 - Fax: 949.425.1738