Asteria Health	Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.
Changes to the credit card on file will require a new authorization form with the updated card information.

Credit Card Information

Card Type: ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **American Express**
☐ **Other** _____

Company Name:

Cardholder Name (as shown on card):

Card Number:

Expiration Date:

Security Code (3 digits on back or 4 digits on front):

Billing Address:

Authorization:

I, _____, authorize Asteria Health to charge my credit card above for agreed upon purchases. I understand my information will be saved for future transactions/purchases on my account. I also understand I must contact Asteria Health to cancel this authorization or to update any credit card information.

_____ _____
Customer Signature Date

Office Contact Information

Contact Name (Accounts Payable/Office Manager):

Contact Phone:

Contact Email:

Return completed form to info@asteriahealth.com or fax to (844)771-0505