# CREDIT CARD AUTHORIZATION

COMPANY NAME: ____________________

ACCOUNT NUMBER: ____________________

**CREDIT CARD TYPE: (Check One):**

Visa     MasterCard

**CREDIT CARD NUMBER:** ____________________

**SECURITY CODE:** __________ **EXPIRATION DATE:** __________
(3 OR 4 digit code)

BILLING NAME AND ADDRESS AS IT APPEARS ON YOUR CREDIT CARD STATEMENT:

____________________

____________________

____________________

NAME AS IT APPEARS ON YOUR CARD:

____________________

**ACCOUNT TO BE CHARGED:**

BY INVOICE WHEN ORDER PLACED

No receipt can be provided as our system automatically charges credit card

Receipt can be provided with email address entered below by checking the box

OTHER: Please give details: ____________________

The undersigned owner or authorized officer on the account above does hereby authorize Skya Health, LLC to charge the credit card for the amount of each order. The amount of each charge will be reflected on the statement received from Skya Health, LLC, unless a dispute is brought to the attention of Skya within 3 business days from the receipt of goods from Skya. This authorization shall continue until the card listed above expires (or replacement thereof) or until you notify Skya.

**AUTHORIZED SIGNATURE:** ____________________ **DATE:** ____________________

Email receipt by checking this box ____________________

**Once form has been completed and signed, email to orders@skyahealth.com**