

# Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.  
All information will remain confidential

Name on Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

Credit Card Type: \_\_\_\_\_ Visa \_\_\_\_\_ Mastercard \_\_\_\_\_ Discover \_\_\_\_\_ AmEx

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Card Identification Number: \_\_\_\_\_ (last 3 digits located on the back of the credit card)

Amount to Charge: \$ \_\_\_\_\_ (USD)

I authorize ADVANCED PAIN MANAGEMENT CENTER to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Return the completed and signed form to the following:**

FAX: 702-738-8608

or

EMAIL [fmlaapmc@gmail.com](mailto:fmlaapmc@gmail.com)