CROWN MEDICAL SERVICES

1750 California Ave. # 116
Corona, CA 92881

AUTHORIZATION FOR CREDIT CARD PAYMENTS

Credit Card: VISA MASTERCARD DISCOVER AMEX

Credit Card Number:_____

Expiration Date:_____

CVV Code:_____

Name on the Card:_____

Facility or Business Name:_____

Billing Address:_____

City:_____State:_____Zip:_____

By signing below, I authorize **CROWN MEDICAL SERVICES** to charge my credit card for the product purchased. I also authorize **CROWN MEDICAL SERVICES** To charge for any open invoices if account is not paid within 2 days after due date. I also authorize **CROWN MEDICAL SERVICES** to charge any credit card given verbally by the authorized person.

Signature _____ Date: _____

Please complete the form and fax to 951-735-1109