



A-1 MEDICAL INTEGRATION

CREDIT CARD AUTHORIZATION

Show/Project Name: _____

Card Holder's Name

(as it appears on the card): _____

Card Type:

Visa ___ Master Card ___ AmEx ___ Discover ___ Other ___

Card Account Number: _____

Expiration Date: _____

CVV: _____ (3-digit code on back, or 4-digit code on front for Amex)

Billing Zip Code: _____

(Actual address the credit card is billed to, not necessarily the production company address.)

Card Holder's Billing Address: _____

Card Holder's Phone Number: _____

Email Address

(paid invoices will be emailed here): _____

I authorize A-1 Medical Integration to charge the above listed credit card, for all rentals and sales items agreed upon.

Card Holder's Signature (or other authorized user): _____ Date: _____

