One (1) Time Credit Card Payment Authorization

Sign and complete this form to Authorize *Family Eyecare of Glendale* to make a one-time charge to your credit card listed below.

By signing this form, you give Family Eyecare of Glendale permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

I, ____________________________________authorize Family Eyecare of Glendale to charge my credit/debit card account indicated below for $______________on____/_____/_______.

This payment is for Eyewear/Contact Lenses and/or shipping costs.

Billing Information

Billing Street Address ____

City____________________________ State _____________ Zip Code________________

Phone_________________________ email______________________________________

Card Details

Cardholder Name____

Card Number ____

Expiration Date_______/_______/_______ Verification Code_______________

I authorize Family Eyecare of Glendale to charge the card number indicated for the stated amount according to the terms outlined above. This authorization is valid for one (1) time use only. I certify that Iam an authorized user of this card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in this form.

Signature____Date_______________________