Alliance Healthcare Systems LLC

Credit Card Authorization Form

(Please fill in the form below and return it to us)

By signing this form, I authorize Alliance Healthcare Systems LLC to debit my account for $_____ (USD).

Payment reference: Transportation Services

Card Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover Other:_____

Cardholder Name _____

Card Number _____

Expiration Date (MM/YY) _____

CVV2 (3-digit number on back of Visa/MC, 4 digits on front of AMEX) _____

Billing Address: _____

_____

_____

CARDHOLDER SIGNATURE _____ DATE _____

I authorize the above-named business to charge the credit card indicated in this authorization form. This payment authorization is for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company. I understand that the payment is non-refundable.