



ONCOLOGY CONSULTANTS

Credit Card Payment Authorization Form

Instruction: To pay by credit card, please complete all sections below and email a signed copy to info@ocbahamas.com along with a **copy of a government-issued ID**.

By signing this form, you give permission to charge the credit card indicated 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 charges.

Please complete the information below:

I _____ authorize **ONCOLOGY CONSULTANTS** to charge my credit card
(full name) (company name)

account indicated below for \$ _____
(amount)

This payment is for _____.
(description of goods/services)

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: Visa MasterCard Discover

Cardholder Name _____

Credit Card Number _____

Expiration Date (mm/yy) _____

CVV2 (3-digit number on the back of Visa/MC) _____

SIGNATURE _____

DATE _____

I authorize **ONCOLOGY CONSULTANTS** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one-time use 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 so long as the transaction corresponds to the terms indicated in this form.