FillerCloud

Payment Authorization Form

Medical license number: _____ **License expiry date:** _____

Medical professional name: _____ **Profession:** _____

CREDIT CARD INFORMATION

As the company representative, I hereby authorize this card to be used for the deposit required

Name as it appears on the Card: _____

Credit Card Number: _____ – _____ – _____ – _____

Expiration Date (mm/yy): ___/___ **Type of Card:** ☐ AMEX ☐ VISA ☐ MasterCard

Security back code (3 digits for Visa/MC 4 digits for Amex) _____

BILLING ADDRESS

Street: _____ **City:** _____

State: _____ **Zip code:** _____

Cardholder or Company Representative Signature: _____ **Date:** _____

I hereby authorize this card to be charged the following amount: _____

Choose ONE of the following options below:

- ☐ I allow to automatically charge this credit card for each new order
- ☐ Confirm each new order with me by email or over the phone

701 W Georgia St #1500, Vancouver, BC V7Y 1C6

Phone: 1-604-800-8004

Email: info@fillercloud.com **Fax:** 360.768.3126