Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ AMEX
Cardholder Name (as shown on card):
Card Number: (Last 4 digits only) ____ ____ ____ ____
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):

I,_____, authorize **Synergy Healthcare for Kids Inc.** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date