



Credit Card Authorization Form

Fax completed form to: (818)827-4755

Your completion of this authorization form helps us to protect you, our valued customers, from credit card fraud. Best Quality Health will keep all information entered on this form strictly confidential.

Customer Information

Name : _____
Address : _____
City/State/Zip: _____
Email : _____
Phone : _____

Credit Card Information

Name on Card: _____
Card Number: _____
CVV: _____
Expiration: _____
Billing Address: _____
City/State/Zip: _____

Please Sign and Date

Cardholder's Signature: _____
Date: _____

I, the above signed, give authorization to Best Quality Health to charge the above credit card for the agreed upon purchases. For doctor's consultations and orders, Best Quality Health reserves the right to charge this account without requiring the customer's signed authorization.