Credit Card Authorization

Enter credit card details as shown on the credit card and billing statement.

Name (as it appears on card): _____

Billing Address: _____

Credit Card Type: □ Visa □ MasterCard Credit Card Number: _____

Credit Card Expiration Date: _____ 3-digit CVV Credit Card Code (on back of card): _____

Signature: _____

The above Client/Company authorizes Physician's Liaison, Inc. to charge the credit card listed for the fees outlined in the Physician's Liaison Proposal.

Payment Schedule

Payment schedule for _____ monthly payments. □ 1st of the month □ 15th of the month □ End of the month

Payment Confirmation

Please list the contact information of the company representative who should receive automated payment confirmations indicating that the above credit card has been charged.

Name (if different from above): _____ Email Address: _____