



**Medical Concepts**  
**26690 Madison Ave .**  
**Suite #102**  
**Murrieta CA 92562**  
**951-894-7348**

**One Time Credit Card Payment Authorization Form**

Sign and complete this form to authorize **Medical Concepts** to make a one time debit to your credit card listed below.

By signing this form you give us permission to debit your account 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 debits or credits to your account.

**Please complete the information below:**

I \_\_\_\_\_ authorize **Medical Concepts** to charge my credit card  
 (full name)  
 account indicated below for \_\_\_\_\_ on or after \_\_\_\_\_. This payment is for  
 (amount) (date)  
 \_\_\_\_\_.  
 (description of goods/services)

Billing Address \_\_\_\_\_ Phone# \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

Account Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX <input type="checkbox"/> Discover
Cardholder Name _____
Account Number _____
Expiration Date _____
CSC (3 Digit code) _____

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I authorize the above named business 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.