469 Lawerence Avenue West
Toronto, Ontario, M5M 1C6
Phone: 416.423.3336
Fax: 416.907.0883
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CREDIT CARD AUTHORIZATION FORM

Protected when completed

Date:	**Client Name:**

Address:

	Telephone:
	Driver's License#:

CREDIT CARD INFORMATION (Please print)	
Cardholder's Name:	**Card #:**
Card Type: ❒ MasterCard ❒ Visa ❒ Amex	**Expiry date:** **Amount to be charged: $**
Billing Address (if different from above):	**Card Present** ❒ **Yes** ❒ **No**

I, _____ (cardholder) authorize Ability Healthcare Supplies Inc. to charge on my credit card, the sum of $ _____ for products and services previously discussed – an invoice for which will follow. I have also read, understand and agree to the important information and conditions specified herein.

_____
Date:

_____
Cardholder's signature

❒ PLEASE KEEP CREDIT CARD # ON FILE FOR FUTURE TRANSACTIONS
❒ DO NOT KEEP CREDIT CARD # ON FILE FOR FUTURE TRANSACTIONS

IMPORTANT INFORMATION AND CONDITIONS:

I agree to pay the total amount as entered above according to the card issuer agreement. I further acknowledge that I have read the terms and conditions of the sales agreement stipulated hereon. I understand and agree to these terms and expressly waive any rights to credit card charge backs as a means to mediate disputes.