

Please charge my one time payment for \$\_\_\_\_\_.

VISA       Master Card       Discover       Care Credit

Account # \_\_\_\_\_ Exp Date \_\_\_\_/\_\_\_\_

Name on Card \_\_\_\_\_

Billing Street address \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_