Cutting Edge Testing LLC
4835 Van Nuys Blvd., Ste. 117
Sherman Oaks CA, 91403
Phone: (818) 386-2132 / FAX 1(818) 386-9827

Credit Card on File Payment Authorization Form

Please complete the information below:

I _____ authorize Cutting Edge Testing (C.E.T.) to charge my credit card
(full name)
indicated below and keep it on file when I request testing services by Phone, Text, FAX or Email.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name

Credit Card #

Expiration Date

CVV2 (3 digit number on back of Visa/MC/Discover)

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. 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; provided the transactions correspond to the terms indicated in this authorization form.

(DRAW STATION MUST INITIAL WHEN PATIENT PRESENTS IDENTIFICATION & CREDIT CARD TO MATCH)

PLEASE VERIFY ID (BELOW):
(CORRESPONDS TO CREDIT CARD) _____

PLEASE VERIFY CREDIT CARD (BELOW):
(CORRESPONDS TO ID) _____