



**Thriving Audiology**

Credit Card Payment Form

FAX to 1-907-696-4119

**Person / Company Making Payment**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/ST/Zip \_\_\_\_\_  
Contact \_\_\_\_\_  
Phone \_\_\_\_\_  
FAX \_\_\_\_\_  
E-Mail \_\_\_\_\_

**Credit Card Information**

Card Type \_\_\_\_\_ VISA or MasterCard  
Card Number \_\_\_\_\_  
Expiration Date \_\_\_\_\_ / \_\_\_\_\_  
Name As On the Card \_\_\_\_\_  
Billing Address \_\_\_\_\_  
City & State/Province \_\_\_\_\_  
Zip/Postal Code/Country \_\_\_\_\_

- This is an Authorization for a One Time Payment:  
Payment Amount \_\_\_\_\_
- This is an Authorization for a series of payments:  
In the amount of \_\_\_\_\_ to be made on or about the  
first day of each month.
- This is an Authorization for my monthly amount due to be  
paid on or about the first day of each month.

I understand the nature of the services I am to receive and I agree to be charged the amount indicated above for services from Thriving LLC, dba Thriving Audiology, using the credit card listed above. I certify that I am authorized to execute this transaction and understand in the event I make an error and overpay the refund will be made to the same credit card.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Company

\_\_\_\_\_  
Date