REACTHEALTH

Authorization Form

☐ Credit Card OR ☐ Debit Card

[ ] AMEX [ ] DISCOVER [ ] MASTERCARD [ ] VISA

Card Holder Name: ____

Company Name: ____

Billing Address: ____

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Credit Card Number: ____

Expiration Date: _______________ CSV Code: ____________________

Invoice(s): ____

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Should __________________________________ account go beyond payment terms, I authorize React Health to charge the above card for full payment. Full payment could be a one-time payment or payment in increments at React Health's discretion. Any changes to this card will be communicated to React Health immediately with updated card information. Customer agrees not to dispute credit card charges.

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Name (Print) Authorized signature on behalf of Company Date