PRISM HEALTH SERVICES, LLC.
Be Home, Be Safe, Be Happy.

Credit Card Authorization Form

I, _____ hereby, authorize PRISM HEALTH SERVICES, LLC to charge my Credit Card provided below every month on _____ towards my dues / subscription / rental payment of _____.

I will notify Prism Health Services, LLC of any changes in the Credit Card information as soon as it occurs and provide them with the updated information. I may be liable to pay additional charges and / or discontinuation of my services, if my payments are delayed due to inadequate / inaccurate information with Prism Health Services, LLC. If the services are discontinued due to these reasons and in an event something unforeseen happens I agree to NOT hold PRISM HEALTH SERVICES, LLC liable for any serious consequences, damages / injuries.

I take full responsibility of ensuring that the unit is always charged and connected.

CREDIT CARD INFORMATION: (*Please write legibly***)**

NAME ON CARD: _____

BILLING ADDRESS: _____

_____ZIP: _____

TYPE OF CARD: VISA / MC/ DISCOVER / AMEX/ Other: _____

CARD#: _____

EXP. DATE: _____ CVC: _____

Card Holders' Signature: X_____

Please Mail Completed Form to: Prism Health Services LLC

6971 Business Park Blvd. N

Jacksonville FL 32256

Or Scan and Email to: info@prismhealthservices.net