Angelus
Medical & Optical
1835 W. Rosecrans Ave, Unit A
Gardena, CA 90249

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CREDIT CARD AUTHORIZATION FORM

Phone: (310) 769-6060
Fax: (310) 769-1999
Email: info@angelusmedical.com
URL: www.angelusmedical.com

Invoice / Quote Number: _____

I _____ authorize Angelus Medical & Optical to charge my Credit Card.

Contact Name: _____ Contact Phone No.: _____

Contact email Address:

Card Type: Visa / Master Card / Discover/American Express (please circle one)

Card No: _____ Expiration Date: _____

Security code: _____ (4 digits on the front for Amex, 3 digits on the back for all the other ones)

Billing Address Zip Code: _____

Name On the Card: _____

Credit Card Billing address including the zip code:

_____

_____

_____

Shipping address (If different):

_____

_____

_____

I here by authorize delivery of merchandise to the shipping address above which is not my credit card billing address, I agree that I will pay for this purchase and indemnify and hold Angelus Medical & Optical harmless against any liability pursuant to this authorization. I understand that my signature in this form will serve as my authorized signature on the credit card charge slip.

_____ _____ _____

PRINT Card Holder Name Signature Date

Angelus
Medical & Optical

13007 S. Western Ave.
Gardena, CA 90249

For all orders to be paid with credit card, please complete, print and FAX the “Credit Card Authorization Form” to Angelus Medical & Optical

Authorization Instructions:

- **Complete form (Must include bill to address and amount)**
- **Cardholder must include signature**
- **Fax (310) 769 -1999**

At the request of the Credit Card Company, all telephone orders require a signature prior to processing the charges on your credit card.

Please confirm your request by signing and returning faxing the completed for to (310) 769-1999