VISIONBIOPHARMA
Quality Packaging Supply & More

800 795 0850
818 885 4504
sales@visionbiopharma.com

CREDIT CARD AUTHORIZATION FORM

Card holder's Name: _____

Credit Card #: _____

Expiration Date: _____ / _____ CVV: _____

Credit Card #: ☐ Amex ☐ Visa ☐ Mastercard

Billing Address: _____

Contact Phone Number: _____

I, _____, authorize Vision BioPharma to charge to my above credit card for current invoice pertaining to the open order. If the shipping address differs from the billing address, I authorize Vision BioPharma to ship the product to the shipping address. I agree to pay the above total amount according to the credit card issuer agreement. Vision BioPharma will not be responsible for any charge back.

Card holder signature: _____ **Date:** _____

Please email to **sales@visionbiopharma.com** or fax back to vision BioPharma at **818 885 4504** per credit card issuer requirement, vision BioPharma must have this form on file before an order can be charged, released, and shipped.

Vision BioPharma
3200 Kirkwood Hwy Ste #1067
Wilmington, DE 19808
Contact us at 800 795 0850
sales@visionbiopharma.com

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