20 West St #29D. New York, New York 10004
(844)-BIOTICS
www.linkedbiotics.com

Wholesale Account Credit Card Payment Authorization Form

Sign and complete this form to authorize Linked Health, Inc to make approved debit(s) to your credit card listed below.

By signing this form you give us permission to debit your account for amounts approved as indicated on or after the signed date. This is permission for any number of transaction authorized by the signed account holder below. Authorizations may be submitted through email by responding to invoices and only by the approved account holder address(s) listed below. In addition, you give permission to store this credit card authorization securely through our encrypted PCI compliant payment processor.

I, _____, authorize Linked Health, Inc to charge my credit card
(print full name)

account indicated below for any amounts up to $_____ on or after _____.
(max. amount) (initial transaction date)

Cardholder Billing Details:

First Name:	Last Name:

Company:	
Website:	Phone:

Address:		
City:	State:	Zip Code:

Credit Card #:	Exp:	CVV:

Billing Preferences:

Please list all any email address you approve for future authorizations:

Account Holder Signature:_____ Date:_____

The details provided in this document will be stored in an encrypted vault provided by Braintree, a Division of PayPal, Inc. The original document will be destroyed upon transfer of data. We encourage destruction of all documents containing credit card information after completion of processing. At Linked Health, your information and privacy is held in the highest regard.