

# Credit Card Authorization Form



## Payment Options

We offer our Members two choices for payment of your monthly membership fees. We process invoices on the first of each month. If you would like to pay by check, you will receive your invoice in the mail. If you would prefer to pay by credit card, please fill out the form below. We will then process your credit card on the day indicated, and email you a copy of your receipt at that time.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Credit Card Information:

Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ Discover Card \_\_\_\_\_

Name on Card: \_\_\_\_\_

Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_

I hereby authorize Professional Eye Care Associates of America to process my monthly PECAA fees in the amount of \$299.00 on the 1st \_\_\_\_\_ or the 15th \_\_\_\_\_ day of each month.

Signature

Date

Professional Eye Care Associates of America  
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