Convenience ▪ Affordability ▪ Choice™

Byram HEALTHCARE®
Part of the Owens & Minor Family

Credit Card Authorization Form

Please complete this form and email it to:
billingliaison@byramhealthcare.com

Customer Account Number: _____

Customer Name: _____

Company Name: _____
(if applicable)

Shipping Address *(if different from billing address below)*

Address: _____

City: _____ **State:** _____ **Zip:** _____

**For multiple shipping address with the same credit card please complete a form for each shipping address.*

Credit Card Information

Card Type: **Visa** **MasterCard** **American Express** **Other**

Cardholder(s) Name: _____
(as it appears on your card)

Address: _____
(as it appears on the credit card account)

City: _____ **State:** _____ **Zip:** _____

Please provide last 4 digits of the credit card on file: _____
(card that was provided to set up payment plan)

I hereby authorize delivery of product to the shipping address above, which may not be the credit card billing address. I agree that I will pay for this purchase, and any subsequent order/purchase I authorize, and indemnify and hold BYRAM HEALTHCARE CENTERS, INC. ("Company") harmless, against any liability pursuant to this authorization. I understand that my signature on this form will serve as my authorized signature on credit card charge slips. I understand and agree to the terms and conditions as outlined on the invoice. I also authorize product to be left at my credit card billing address and/or other shipping address without obtaining a signature on a credit card charge slip. I agree that Company is not responsible for purchases that are late, lost or stolen if I, or my designated recipient, do(es) not sign for a purchase for any reason. I hereby authorize Company to charge the credit card noted for payments of fees, costs, and expenses that are incurred by me or any member or employee of my professional organization stated above. I certify that I am authorized to sign this form on behalf of this organization and will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in this form. I understand that charges will be made to this credit card account and if the credit card is declined for any reason I will be responsible for payment of any outstanding charges and fees resulting from the declination. I under-stand that this pre-authorization may be revoked at any time by providing Company notice of my intent to stop payment at least three (3) days before the scheduled date of billing.

Signature: _____ Date: _____