SIBO Diagnostics – Authorization of Payment Processing

I, _____, authorize SIBO Diagnostics to bill my account for all charges incurred using the card information below at the time of purchase. Furthermore, I acknowledge and understand that my card will be saved on file for future transactions on this account. I understand that it is my responsibility to keep my billing information up to date, and that declined transactions may incur additional fees, at the sole discretion of SIBO Diagnostics.

Credit Card Type (please check one): ☐ **MasterCard** ☐ **Visa**

Cardholder Name (as shown on Card): _____

Card Number: _____/_____/_____/_____ **Expiry Date:** _____/_____

Security Code (3-digit CVV)**:** _____

Clinic Name: _____

Billing Address: _____

_____

_____ _____

Cardholder Signature **Date**

Please email or fax completed form to info@sibodiagnostics.com or 778.698.1926

*Please note: We only accept **MasterCard** and **Visa**.
We cannot process American Express, Visa Debit, etc.