Astor Pharmaceuticals LLC

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____CVV_____
Expiration Date (mm/yy): _____
Cardholder Billing Address, City State and ZIP Code (from credit card billing address):

_____
_____
_____

Email:_____

I, _____, authorize Astor Drugs to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. A 3% Credit Card service fee will be applied to each transaction.

_____ _____
Customer Signature Date

Company Name:_____