817 E 66th Street
Richfield, MN 55423
Tel: (612) 488-1566
Fax: (612) 488-1564
Email: billing@swoopeye.com

ONE TIME CREDIT CARD AUTHORIZATION FORM FOR EYEWEAR NON-COVERED EYE WEAR

By signing this form, you are authorizing Swoop Eye care to charge your credit card for the amount indicated on or after the indicated date (up to six months). This gives Swoop Eye Care permission to bill you for the remaining balance or non-covered products/enhancements (anti-reflective, tint, transitions, etc.) provided in office for your prescription eye wear. I, _____, authorize **Swoop Eye Care** to charge my credit card for the remaining balance pertaining to the remaining balance for my prescription eye wear and/or enhancements. The price may not exceed the list pricing below.

Your **prescription eye wear pair #1** full cost is as follows: _____.

Your **prescription eye wear pair #2** full cost is as follows:_____.

Your **prescription eye wear pair #3** full cost is as follows**:** _____.

BILLING INFORMATION

Billing Address: _____**City, State, Zip**: _____, _____, _____

Phone #: _____ **Email**: _____

CREDIT CARD INFORMATION

Card Type: ☐ Mastercard | ☐ VISA | ☐ Discover | ☐ AMEX | ☐ Other [OTHER]

Cardholder Name: _____

Card Number (#): _____

Expiration: **_____CVV**: _____ **Cardholder ZIP:** _____

CARDHOLDER SIGNATURE

I authorize Swoop Eye Care to charge the credit card indicated in this authorization form according to the above-mentioned terms. This payment authorization is for eye wear/enhancements described above, for the amount indicated above. I certify that I am an authorized user of this credit card and will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Cardholder Signature: _____ **Date**: _____

Printed Name: _____