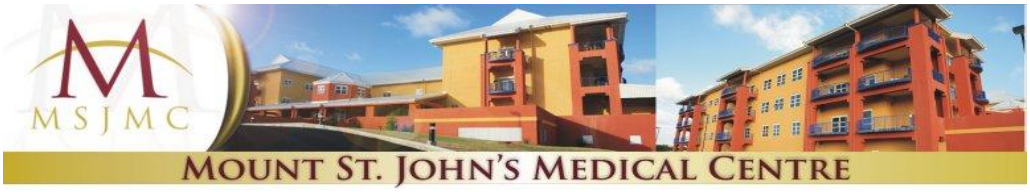

Michael's Mount
St John's
Antigua
1-268-484-2700

One Time Credit Card Payment Authorization Form

Sign and complete this form to authorize **Mount St John's Medical Center** to make a one-time debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize **Mount St John's Medical Center** to charge my
(full name)
credit card .

account indicated below for _____ on or after _____. This payment is for
(amount USD) **(date)**

_____
(description of goods/services)

Billing Address_____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard

Cardholder Name _____

Card Number _____

Expiration Date _____

CCV Number _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.