



MAIN MEDICAL  
Credit Card Transaction Form

\*All of the following fields must be completed in order to process a credit card transaction.

**To avoid delay in processing, PLEASE PRINT CLEARLY**

Re: Invoice # \_\_\_\_\_

**First Name:** \_\_\_\_\_  
(As it appears on the card)

**Middle Name/Initial:** \_\_\_\_\_  
(As it appears on the card)

**Last Name:** \_\_\_\_\_  
(As it appears on the card)

**Type of Card:**      VISA \_\_\_\_\_      MASTERCARD \_\_\_\_\_

**Credit Card #:** \_\_\_\_\_

**Credit Card Security Code:** \_\_\_\_\_  
(This is a three-digit number that appears on the back of the card usually in the signature field)

**Card Expiration Date:** \_\_\_\_ / \_\_\_\_\_

**Credit Card Billing Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Contact Phone Number for Cardholder:** \_\_\_\_\_

I authorize Business Records Management LLC to charge my credit card account in the amount of \$\_\_\_\_\_ for photocopying and postage fees.

**Authorized Signature:** \_\_\_\_\_