the spectrum group

including:
Spectrum Labs
Spectrum Health Care
Spectrum Worldwide

CREDIT CARD PAYMENT AUTHORIZATION

Date: _____

Client Account Number: _____

Credit card type: Visa Mastercard Amex

Credit Card Number: __ __ __ __-__ __ __ __-__ __ __ __- __ __ __ __

Expiration Date: _____ Security Code: _____

Name on Credit Card: _____

Billing Address: _____

_____

_____

Your credit card will be billed on the date results are provided.
Invoices will be generated and emailed for your records.

Authorized by: _____

Complete and fax to: 480-464-0364