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One Time Credit Card Payment Authorization Form

Sign and complete this form to authorize getMedOnline.com-Asteria Inc. 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 getMedOnline.com-Asteria Inc. to charge my credit card account indicated below for _____ on or after _____. This payment is for _____.

Bill To Address _____

Phone# _____

City, State, Zip _____

Email _____

Ship To Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: <input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> AMEX	<input type="checkbox"/> Discover
Cardholder Name _____			
Account Number _____			
Expiration Date _____			
CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____			

SIGNATURE _____

DATE _____

I authorize getMedOnline.com-Asteria Inc. 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.