



CREDIT CARD AUTHORIZATION FORM

I hereby give permission for InterpStudies, LLC to charge:
\$69.00 for home sleep study interpretations using SleepMed ARES.

The information to charge my card is as follows:

Circle one: VISA MASTERCARD DISCOVER AMEX

Credit Card Number	
Expiration Date	Verification Number
Name printed on card	

Name(s) of Ordering Doctors	DMD/DDS
Practice name	

Practice address

Street		
City	State	Zip
Phone number	Fax number	
Email Address		

Billing address

Street		
City	State	Zip

By signing this document, you authorize InterpStudies, LLC to electronically debit your credit card for completed physician interpretations of home sleep studies obtained through our company.

Cardholder's signature _____

Date _____

Please email or fax to:

InterpStudies, LLC
5114 State Route 21 South
Canandaigua, NY 14424
interpstudies@gmail.com
(585)-394-6524

Please contact the Billing Department at 585-394-6524 with any concerns.