



Priority Health Education

where your success is our priority

# CREDIT CARD PAYMENT FORM

**STUDENT NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**Credit Card Billing Address:** (If different from above address)

\_\_\_\_\_

**Name on Credit Card:** (If different from Student Name)

\_\_\_\_\_

**Credit Card Number:**

\_\_\_\_\_

**Expiration Date:**

\_\_\_\_\_

**CSC Number:** (The 3-digit number located on the back of the card)

\_\_\_\_\_

**Type of Card:** (Please Circle)    Master Card    Visa    Discover    **Amount Paid:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_