



Phone: 346-816-7961
Fax: 346-816-7960
Website: www.ihelphealthcare.com
email: ihelpinc@yahoo.com

The undersigned cardholder hereby instructs and authorizes Ihelp Healthcare Services, Inc. to charge the credit card described below for charges invoiced for home care services rendered for:

Client

Credit Application

- Visa Master Card American Express Discover

Credit Card Number _____/_____
Expiration Date _____
VID (3-4 numbers on card)

Name of Card Holder

Credit Card Billing Address

Street

City _____
State _____
Zip

As the credit cardholder described above, I hereby authorize payment for services delivered and invoiced by I Help Healthcare, Inc.

Cardholder's Signature _____
Date

Please fill in document then print and sign. You may then scan and return via email or mail to:
iHelp Healthcare • 9442 Ruby Mist Dr., Rosharon, Tx 77583