Sleep Inn
1050 Claussen Road - Augusta, Georgia 30907
(706) 738-7473 phone – (706) 733-3551 fax

Credit Card Payment Authorization Form

FAX COMPLETED FORM TO: 706-733-3551 **ATTN:** ______________________________

STAY INFORMATION: **Date:** ___________________________

Guest Name:	
Check-In Date:	Number of Nights:
Name of Person/Group Making Reservation:	Phone:

CARDHOLDER - Please complete the following section and sign/date below.

Cardholder Name as it Appears on Credit Card:		
Cardholder Billing Address:		
City:	State:	Zip:
Daytime /Business Telephone:	Evening Telephone:	
Credit Card Number:	Expiration Date:	
Credit Card Issuing Bank Name:	Bank Phone Number (from back of your credit card):	
I agree to cover All Room Charges for the stay (Long Distance is free) I agree to cover the above categories of charges up to a Maximum Amount of $ _________________		
DIRECT BILL ACCOUNT PAYMENTS ONLY: Name on Invoice/Statement_________________________________ ______ ________ Invoice/Statement Number ________________________ _____________	Date on Invoice/Statement ___________________ Authorized Amount $______________________	

Note: Charges for room and tax, group deposits or direct bill account payments will be charged to your credit card immediately. Any incidental charges circled above will be charged at the time of check-out.

Amount to be immediately charged to credit card for room and taxes or deposit: $_____________

Final Balance Billed to Credit Card (hotel use only): $______________

By signing below, you authorize the hotel to charge your credit card for the amount indicated above up to the “Maximum Amount” indicated above. You further acknowledge responsibility for any damages / items removed from rooms during stay.

Cardholder Signature: Date: