Payment Authorization

www.AdvantageIntegrative.com

I, _____
(Print Name)
authorize Advantage Integrative Health, L.L.C. to bill my credit card for products an/or services provided as listed below.

Credit Card Details

Name on Credit Card _____

Credit Card Holder's Billing Address (Where your statement is mailed)

Street: _____

City: _____ State: _____ Zip: _____

Email: _____ Cell Phone: _____
☐ Ok to email receipts/reminders ☐ Ok to text receipts/reminders

Type of credit card (please check one): ☐ Visa ☐ MasterCard ☐ American Express

Card #: _____ Exp. date: _____

Last 3 digits (4 for Amex on front) on back of card: _____
(found on the back of your credit card on the signature panel)

Client Information ☐ Check if same as credit card details above
Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Authorization

Signature: _____Today's Date: _____
Card Holder's Signature

This authorization may be revoked at any time when the following stipulations have been performed.
1. A new financial agreement has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Client's account is paid in full.