Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

_____ Zip Code: _____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: Month: _____ Year: _____

Card Identification Number: _____ (last 3 or 4 digits located on the back of the credit card)

Amount to Charge: $ _____ (USD)

Is this card linked to an HSA/Flex Spending Account? Yes No

Please let Shine Wellness Clinic know if you wish to change or delete your card at any time.

I authorize Shine Wellness Clinic to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

Revised: 6-24