



### CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by submitting a signed request to do so. This authorization will remain in effect until cancelled.

#### CREDIT CARD INFORMATION:

Cardholder Name (as shown on card): \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVC Code: \_\_\_\_\_

Card Type: VISA      MASTERCARD      AMEX      DISCOVER

Is this an HSA or FSA card?      YES      NO

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**This card is approved for the following additional people** (*If names are listed on this form, you have given Holistic Health Associates approval to take payment on their accounts with the credit card listed on this form*):

\_\_\_\_\_

I \_\_\_\_\_, authorize Holistic Health Associates to charge my credit card above for services rendered and/or agreed upon purchases. I understand that my information will be securely saved to file for future transactions on my account.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Customer Signature**

**Date**