



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 *If you choose this option, please complete an additional form with your non-HSA card for non-service related charges.*

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