

Credit Card Authorization

Name of Card Holder:	
Account #:	
Expires:	Billing Address:
Conditions: Bill this card for: ___ All of my phoned in supplement orders ___ For any canceled or missed appointments without 48 business hours notice	
I grant permission to Rejuvenation & Well Being to charge the above credit card for services and/or supplements based on the above marked conditions. I understand that I am responsible for communicating to the office any change to the above payment method and/or conditions.	
Signature of Card Holder: _____	Date: _____