Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. **This authorization will remain in effect until cancelled.**

Credit Card Information

Card Type: ⏭ Mastercard ⏭ Visa ⏭ Discover ⏭ AmEx
⏭ Other _____

Cardholder Name (as shown on card): _____

Last 4 digits of Card Number: _____

Expiration Date (mm/yy): _____

Cardholder ZIP code (from credit card billing address): _____

I, _____, authorize Ken Starr Wellness Group to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Credit Card Owner Signature Date

Patient Name (if different from card holder) Date

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