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Tax ID: 33-0595860 California Lic# A40090

AUTHORIZATION TO CHARGE CREDIT CARD

Patient's Name: _____ Date of Birth: _____

Cardholder's Name: _____

Credit Card Type: Visa Master Card American Express Discover

Credit Card Number: _____

Expiration Date: _____ CVC2 Code: _____

Payment Amount: \$ _____

Cardholder's Signature: _____ Date: _____

CREDIT CARD BILLING ADDRESS

Street Address: _____

City/State/Zip: _____

Home Phone# _____ Cell Phone# _____

Cardholder agrees to pay in accordance with agreement governing use of such card.

PLEASE NOTE: Chargebacks and declined transactions may be subject to an additional handling fee.

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