



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 final payment is collected.

Credit Card Information	
Card Type:	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card):	_____
Card Number:	_____
Expiration Date (mm/yy):	_____ Security Code: _____
Cardholder ZIP Code (from credit card billing address):	_____
<input checked="" type="checkbox"/> Payment 1: Deposit amount: <u>\$50</u>	<input checked="" type="checkbox"/> Payment 2: Remaining balance: \$ _____

I, _____, authorize Jennifer Randolph L.Ac., MTOM / San Pedro Acupuncture Health Center to charge my credit card above for the agreed upon amount. I understand that my information will be saved until the final payment is collected.

Customer Signature

Date