**CREDIT CARD CHARGE AUTHORIZATION**

**Purpose:** Use this form to authorize Encompass Nutrition LLC to charge payments to a credit card.

**Instructions:** Print or type. Send the completed form with other required documentation to Encompass Nutrition at the above address.

**CUSTOMER INFORMATION**

**Patient Name:**       **BIRTH DATE (mm/dd/yyyy)**

**CREDIT CARD HOLDER INFORMATION**

**Card Holder Name:**       **MAILING ADDRESS**
**CITY**       **STATE**       **ZIP CODE (required)**       **DAYTIME TELEPHONE NUMBER**

**AUTHORIZATION**

**I authorize Encompass Nutrition LLC to charge the credit card account listed**

**DATE (mm/dd/yyyy)**       **Circle one: VISA MASTERCARD DISCOVER**

**NAME APPEARING ON CREDIT CARD**

**CARD HOLDER *SIGNATURE*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CREDIT CARD NUMBER**       **CARD EXPIRATION DATE (MM/YY)**

**3-digit CCV Code (on back of card)**

**AMOUNT TO BE CHARGED**

**\_\_\_\_\_\_\_\_\_\_\_ (initial) Copays in the amount of**       **\_\_\_\_\_\_\_\_\_\_\_ (Initial) Monthly Balance on Account**

**\_\_\_\_\_\_\_\_\_\_\_ (Initial) One Time Charge of $**