BUCKHEAD FUNCTIONAL MEDICINE

3193 Howell mill RD Suite 316

Atlanta, Ga 30327

Credit Card Authorization Agreement Form

I _____ authorize Buckhead Functional Medicine to charge my credit card below for agreed upon charges.

I understand that my information will be saved to file for future transactions on my account.

CLIENT SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

CREDIT CARD INFORMATION

NAME ON CARD:

CARD BILLING ADDRESS

CARD NUMBER:

❑ VISA ❑ MASTERCARD ❑ DISCOVER ____ AMEX

EXPIRATION DATE (MM/YY) / SECURITY CODE

I authorize Buckhead Functional Medicine to retain this credit card information and process the initial and/or future office visit/programs charges.

CLIENT SIGNATURE: _____