

East-West Integrative Medicine
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CREDIT CARD CHARGE AUTHORIZATION

THE FOLLOWING MUST BE FILLED OUT COMPLETELY AND SIGNED BY CREDIT CARD HOLDER

Name as it appears on Credit Card _____

Billing Address (Address where you receive your bill)

City _____ State _____ Zip _____

Contact Telephone Number _____

I authorize Dr. Elaine Chu, East-West Integrative Medicine to charge my credit card account for services or products provided. I agree to pay all charges. This authorization shall continue until withdrawn by me in writing. I agree not to charge-back any services or products that I have already received.

Last 4 digits of Credit Card Account Number _ _ _ _

EXP DATE _____ / _____

SIGNED _____ **DATE** _____