Wholeness Center
A PLACE FOR COLLABORATIVE CARE

phone 970.221.1106
fax 970.232.1050
www.wholeness.com

CREDIT CARD AUTHORIZATION FORM

Patient's Name: _____

Name on Credit Card: _____

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration: __ __ /__ __ Card Verification Code: __ __ __

Billing Address and Zip Code:

_____

_____

I authorize Wholeness Center, PC to bill my credit card for payment of services, laboratory testing and/or supplements.

I certify that I am a person who is authorized to use this credit card.

Signature: _____

Date: _____