# CREDIT CARD AUTHORIZATION

KETAMINE WELLNESS CLINIC
ORANGE COUNTY

**Please complete the form as completely as possible. This authorization can be withdrawn at any time.**

## Credit Card Information

Cardholder Name (as written on the card) _____

Card Number _____

Expiration Date _____/_____/_____ CVV (back of card) _____

## Billing Information

Address _____

City _____ State _____ Zip _____

Phone (_____) _____-_____

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I, _____, authorize Ketamine Wellness Clinic of Orange County to charge the credit card detailed above for agreed upon payments of $ _____ per infusion. I acknowledge that my information will be kept on file for future transactions.

I also certify that I am the owner of the credit card described above and will not dispute the scheduled payments with my bank/credit card company; provided that the transactions correctly correspond with the terms written on this authorization form.

**Authorized Signature** _____

**Print Name** _____

**Date** _____/_____/_____