Anti-Aging and Wellness Medical™

Elite Wellness Beyond Borders.

Email: info@antiagemedical.com
FAX: 1-561-325-7080

Credit Card Payment Authorization Form

Sign and complete this form to authorize Anti-Aging and Wellness to make debit to your credit card listed below.

By signing this form, you give us permission to debit your account.

Please complete the information below:

I _____ authorize Anti-Aging and Wellness to charge my credit card
(full name)

account indicated below. These charges will correspond to My personal treatment.

My shipping address is: _____ Zip Code: _____

My CC billing address is: _____ Zip Code: _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

Security Code _____

SIGNATURE _____ DATE _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.