

Integrative Therapies for Prevention, Cancer and Chronic Disease

Credit Card Authorization

The following conditions apply to the recurring payments program:

1. If any payment is refused by a bank or credit card issuer you may no longer be eligible for recurring payments and may be discharged from Integrative Therapies for Prevention, Cancer and Chronic Disease.
2. All future installment payments will be processed via recurring payments as required by the Integrative Therapies for Prevention, Cancer and Chronic Disease Patient Handbook.
3. You may discontinue the recurring credit card plan anytime by providing Integrative Therapies for Prevention, Cancer and Chronic Disease with 30 days written notice. Please be aware that Integrative Therapies for Prevention, Cancer and Chronic Disease financial policy requires recurring Visa, MasterCard for all monthly and quarterly payments.

The undersigned authorizes Integrative Therapies for Prevention, Cancer and Chronic Disease to debit my Visa or MasterCard for future payments AND for any outstanding balances due on my Integrative Therapies for Prevention, Cancer and Chronic Disease. **Please circle one:**

Option 1: Annual Fee Program (insurance billing)

Option 2 : Membership Program (no insurance billing)

Please charge my card \$ _____ per month/quarter/year (circle one) for program services noted above.

I agree to make all future payments under this recurring charge authorization according to my credit card statement. I understand that my Integrative Therapies for Prevention, Cancer and Chronic Disease membership will be subject to cancellation if my credit card is declined or if I contest any recurring charge made under this recurring payments authorization.

ALL RECURRING CHARGES WILL SHOW ON YOUR CREDIT CARD STATEMENT AS INTEGRATIVE THERAPIES FOR PREVENTION, CANCER AND CHRONIC DISEASE.

Patient Name

Card Holder's name
(as it appears on the card)

Credit Card Number

Visa MasterCard

3 Digit Number from Back of Card

Expiration Date

Credit Card
Billing Address

Street Address

City

State

Zip

Signature

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Date

Please email me my monthly receipt to: _____ @ _____.