DR. JILL HEALTH

400 S. MCCASLIN BLVD., STE. 210 - LOUISVILLE, CO 80027
PHONE 303-993-7910 - FAX 303-993-4674

Pre-Authorized Credit Card Charge Agreement

ALL FIELDS ARE REQUIRED

I, _____ , wish to authorize Dr. Jill Health, Inc. to charge my credit card for agreed upon purchases.

I understand that my information will be saved to file for future transactions on my account. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

PAYMENT DETAILS

CARD TYPE: ◯ MASTERCARD ◯ VISA ◯ DISCOVER ◯ AMEX

◯ OTHER _____

CARDHOLDER NAME (AS SHOWN ON CARD): _____

FULL CREDIT CARD NUMBER: _____

CVV CODE: _____ EXPIRATION DATE (MM/YY): _____

BILLING ADDRESS _____

CITY _____ STATE _____

ZIP CODE _____ PHONE _____

CUSTOMER SIGNATURE _____ DATE _____