

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 _____

ALL OF THE INFORMATION HEREIN WILL BE TREATED IN ACCORDANCE WITH ALL APPLICABLE CONFIDENTIALITY LAWS AND PRACTICES AND IS INTENDED SOLELY FOR THE USE OF DR. JILL HEALTH, INC.