FLATIRON
FUNCTIONAL MEDICINE

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 Flatiron Functional Medicine, LLC to charge my credit card for services agreed upon to a maximum charge of $ ________ .

This is only for appointment-related fees and cannot be used for supplement purchases. Upon request, we can provide an authorization form for supplement purchases from Dr. Jill Health, Inc.

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** ________

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.

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 FLATIRON FUNCTIONAL MEDICINE.