HARMONY MEDICA, PLLC.

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CREDIT CARDHOLDER INFORMATION					
NAME ON CREDIT CARD					
TYPE OF CREDIT CARD	VISA	MC	AMEX	DISCOVER	OTHER
TYPE OF ACCOUNT	PERSONAL		BUSINESS		
COMPANY NAME					

ACCOUNT NUMBER					
EXPIRATION DATE		SECURITY CODE (C VV #)			
BILLING ADDRESS					
CITY		STATE		ZIP	
PHONE		EMAIL		CELL	

AUTHORIZED USER OF CREDIT CARD	
NAME	
COMPANY	
PHONE NUMBER	
EMAIL ADDRESS	
IDENTIFICATION	
RELATION TO OWNER	
TYPE OF CHARGES	TELEPHONE CONSULTATIONS
AUTHORIZED AMOUNT	
DATES OF CHARGES	PER OCCURRENCES OVER THE NEXT 12 MONTHS FROM EFFECTIVE DATE BELOW

AUTHORIZATION OF CARD USE

I certify that I am the authorized holder and signer of the credit card referenced above.

I certify that all information above is complete and accurate.

I hereby authorize collection of payment for telephone consultation charges as indicated above. Charges may not exceed the amount listed above in the "AUTHORIZED AMOUNT" field. I understand this is only for up to this amount during the time period of "DATES OF CHARGES" referenced above. If additional charges are going to be authorized a new form will have to be completed.

CARDHOLDER NAME			
SIGNATURE		DATE	