REVIVE
PROACTIVE HEALTH

Please complete, sign, and e-mail to: forms@reviveprohealth.com or Fax to: (561) 419-6082

Credit Card Authorization

Instructions: Please complete and sign Section A OR Section B.

A. I authorize RenewFx Health and Wellness, LLC to keep my signature on file and to charge my credit card account, on an ongoing basis for amounts I owe.
I understand that this authorization is valid for two years from the below date unless I cancel the authorization through written notice. I also agree to contact the merchant if there are any changes to my credit card account information.

Cardholder Name:

FIRST NAME _____LAST NAME _____

Cardholder Address: (Billing Address)

_____

STREET CITY STATE ZIP

If your shipping address is different from your billing address, please enter it here: (Shipping Address)

_____

STREET CITY STATE ZIP

Account Number:

CARD NUMBER _____SECURITY CODE_____

EXPIRATION DATE _____

Signature_____Date_____

B. I don't want my signature on file and understand that I will have to provide my complete credit card information every time I make a purchase or reorder my prescriptions.

Signature_____Date_____