CREDIT CARD AUTHORIZATION FORM

***CREDIT CARD BILLING ADDRESS*:**
NAME

ADDRESS

CITY, STATE, ZIP

EMAIL

PHONE

ACCOUNT TYPE

VISA **MC** **AMEX** **DISCOVER** **OTHER**

CARDHOLDER NAME

CARD NUMBER

EXPIRATION DATE **CVV**

BEING THE CARDHOLDER, BY SIGNING BELOW I UNDERSTAND AND AGREE TO THE TERMS SET FORTH IN THIS AGREEMENT, AGREE TO PAY, AND SPECIFICALLY AUTHORIZE TTX PRIMARY CARE TO CHARGE MY CREDIT CARD. UPON REQUEST, TTX PRIMARY CARE WILL PROVIDE ME WITH AN ITEMIZED STATEMENT DETAILING ALL OF MY CHARGES. I FURTHER AGREE THAT IN THE EVENT MY CREDIT CARD BECOMES INVALID, I WILL PROVIDE TTX PRIMARY CARE WITH A NEW VALID CREDIT CARD UPON REQUEST, TO BE CHARGED FOR THE PAYMENT OF ANY OUTSTANDING BALANCES OWED TO TTX PRIMARY CARE.

____YES, PLEASE SIGN ME UP FOR AUTOMATIC PAYMENT EACH MONTH BY USING THE CREDIT CARD GIVEN ABOVE

DISCLAIMER: By typing your name below, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

Name signed electronically:
Date signed:

Name signed manually:
Date signed: