



Re-Gain Health
& Balance LLC
Cutting-Edge Natural Healthcare & Wellness Solutions

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

| Credit Card Information | |
|---|---|
| Card Type: | <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____ |
| Cardholder Name (as shown on card): _____ | |
| Card Number: | _____ CVV Number _____ |
| Expiration Date (mm/yy): _____ | |
| Cardholder ZIP Code (from credit card billing address): _____ | |

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date