



Teresa McCurry, C.N.H.P.

CREDIT/DEBIT CARD PRE-AUTHORIZATION

Please print, fill out, sign and date, and fax to: 888-289-2171 or

mail to: 101 Old Mountain Rd., Powder Springs, GA 30127

Credit/Debit Card Type (please circle):

VISA

MASTERCARD

DISCOVER

Cardholder Name (as it appears on the card): _____

Card **Billing** Address (the address in which the card statement is mailed to):

Address Line 1: _____

Address Line 2: _____

City, State, Zip, Country: _____

E-mail Address: _____

Credit/Debit Card Number: _____

Expiration Date: (MM/YYYY) _____ **3 digit Security Code on Signature Line:** _____

I, (print name) _____, hereby

authorize Passionate Health to charge fees based on the accompanied Coaching Agreement to the credit/debit card account in the amounts indicated below:

I authorize charges to my account in the amount of: _____ one time only.

OR

I authorize charges to my account in the amount of: _____ per month on or after the _____ day of each month. I authorize for a total of _____ months.

Cardholder's Signature: _____

Date Signed: _____