

# Recurring Credit Card Authorization Form

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US.  
All information will remain confidential.

Cardholder Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Credit Card Type: \_\_\_\_\_ Visa \_\_\_\_\_ Mastercard \_\_\_\_\_ Discover \_\_\_\_\_ AmEx

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Card Identification Number (last 3/4 digits located on the front/back of the credit card): \_\_\_\_\_

Amount to Charge: \$ \_\_\_\_\_ (USD)

I \_\_\_\_\_ authorize Healing Breeze to charge the agreed amount listed above to my credit card provided herein on the \_\_\_\_\_ day of each month. I agree that I will pay for this purchase in accordance with Healing Breeze agreement.

Cardholder – Print Name, Sign and Date Below:

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

Name: \_\_\_\_\_

I understand that this authorization will remain in effect until I cancel the agreement in writing with the 30 days. In addition, I agree to notify Healing Breeze of any changes to my payment information at least 10 days prior to the next payment authorization period. (billing date).

I am the authorized user of this payment card and will not dispute the scheduled payments outlined above.

**Monthly Membership Rate/Type:** \_\_\_\_\_

**Membership Start Date:** \_\_\_\_\_

**Sales Representative:** \_\_\_\_\_

**Healing Breeze  
Memberships  
16846 Royal Crest Dr.  
Houston, TX 77058  
713-352-9562**