



Recurrent Credit Card Payment Authorization Form

Sign and complete this form to authorize **Foot & Ankle Institute of Arizona LLC** to make a debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for recurrent transactions only (every 9 weeks for nail-care & Podiatry House Calls).

Please complete the information below:

I _____ authorize **Foot&Ankle Institute of AZ LLC** to charge my CC
(full name)

account indicated below for _____ on or after _____. This payment is for
(amount) (date)

PODIATRY HOUSE CALLS EVERY 9 WEEKS

(description of goods/services)

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: Visa MasterCard AMEX Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

Zip Code associated with above card: _____ 3 digit security code: _____

SIGNATURE _____

DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for recurrent use every 9 weeks. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.