

# Card authorization form

I, \_\_\_\_\_, give permission to Artesian Spring Oriental Medicine, LLC to charge  
Buyer name Business name

my card for the following purchases. My card details will be stored in my profile and will only be used for approved purchases.

Varies upon services utilized Traditional Chinese Medicine / Facial & Microneedling Services  
Amount authorized Cardholder email Product/service

All fields required

## Card information

### Card type

- MasterCard  
 Discover  
 VISA  
 AMEX

Other

\_\_\_\_\_  
Cardholder (Name on card)

\_\_\_\_\_  
Card number

\_\_\_\_\_  
Expiration date  
(MM/YYYY)

\_\_\_\_\_  
ZIP code  
(From credit card billing address)

## Recurring payments information

### Charge every:

Week Month Quarter Other \_\_\_\_\_

Charge on this date \_\_\_\_\_  
(For example, the 1st of every month)

\_\_\_\_\_  
Payment amount

\_\_\_\_\_  
Product/service sold

### Terms of agreement

(For example, cancellations must be received 1 week prior to expected billing date)

Email receipts

Mail receipts to:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To cancel, contact: \_\_\_\_\_  
(Name and email)

\_\_\_\_\_  
Customer signature

\_\_\_\_\_  
Date