



**Allswell Wellness LLC**  
Your Holistic Healthcare Center

## 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: _____			
Expiration Date (mm/yy): _____			
Cardholder ZIP Code (from credit card billing address): _____			

I, \_\_\_\_\_, authorize Allswell Wellness LLC 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