**Credit Card Authorization for Homeopathic Services**

**CLIENT INFORMATION**

Name:

**I give permission to Gail Wilson, CCH, to charge my credit card in the amounts of $350.00 for the initial consultation and $150.00 per month thereafter for on-going chronic care*.***

**I understand that the fee for the initial consultation will be charged at the time of the consultation; and fees for monthly follow up will be charged on the first day of each month following the initial consultation date.**

**Upon cancellation of services I will not to be charged beyond the final month of communication.**

**CREDIT CARD AUTHORIZATION**

Name on Credit Card:

Type of Credit Card (Visa, MC, Discover, AmEx):

Account Number:

Expiration Date:

Security Code: