Patient Name: _____ Account #_____ Today's Date_____

Payment Method

I authorize Endocrine Metabolic Medical Center to charge the below credit card $95.00 (USD) at the beginning of each month that I participate in their Weight Control Program.

Signed Date

Credit Card Information

Visa Master Card (Circle One)

Card Number

Expiration Date

Name as it appears on the card

Address Credit Card Bill is Sent to

Address 1

Address 2

City State Zip

If you have questions regarding billing, please email lynn@endocrinemetabolic.com.