



HEALTH IN MOTION, LLC
CREDIT CARD AUTHORIZATION FORM
Please fax this completed form to (714)738-1728

Customer Name: _____

Phone Number: _____

Invoice/Reference #'s:

Amount to be charged:

Credit Card Type:

VISA

☐

MC

☐

AM EX

☐

Credit Card Number:

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CCV:

(3-DIGIT CODE ON BACK OF CARD)

Exp date:

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Cardholder's name as it appears on the credit card:

Cardholder's billing address:

Street:

City:

State: Zip:

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IS THIS CARD TO REMAIN ON FILE FOR FUTURE PURCHASES? Yes

☐

No

☐

I, _____, authorize Health In Motion, LLC to charge the credit card listed above.

Signature & Date