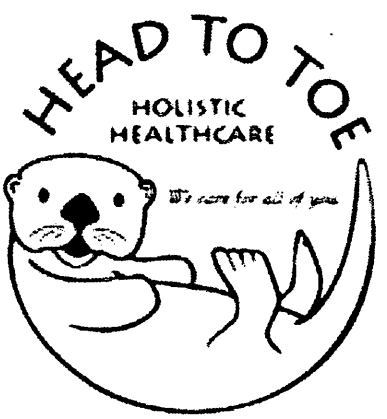

PRE-AUTHORIZED CREDIT CARD
PAYMENT PLAN FORM

Patient Full Name:_____

Phone Numbers (H)_____(W)_____

Card Holder's Name:_____

Card Holder's Address: _____

_____

☐ Visa ☐ MasterCard

Account Number:_____

CVV Security Code: _____ Expiration Date:_____/_____/_____
3-4 digit code

I authorize Head to Toe Holistic Healthcare, LLC to keep my signature on file and to charge my account in monthly installments of $_____. The first installment is due on _ _____/_____/___, and each subsequent payment is due and will be charged to my account on the same day of each consecutive month thereafter until the balance of $_____is paid in full. Past due balances are subject to a Finance Charge equal to actual collection costs plus the current Alaska legal rate of interest.. The responsible party for this delinquent account may be reported to the Credit Bureau of Alaska and/or turned over to our collection agency.

_____ _____
Date Card Holder's Signature (guarantor)

_____ _____
Date Witness

121 West Fireweed Lane, Suite 100, Anchorage, Alaska 99503 (907) 222-6887