INTEGRATIVE AND FUNCTIONAL NUTRITIONIST

JANET ZAROWITZ, MS, RD, CDN

Credit Card Authorization

I hereby give Janet Zarowitz, MS, RD, CDN permission to charge my credit card for services rendered and/or supplements purchased.

Name: _____

Credit Card Type: _____

Credit Card Number: _____

Expiration Date: _____

Security Code: _____

Address with Zip Code Where Credit Card Bills Are Mailed:

_____

I understand that this office has a 24-hour cancellation policy and that my card may be charged for missed appointments.

Signature: _____

Type your name in the “Signature” space above to grant permission to use this credit card for services rendered and/or supplements purchased.

141 N. STATE RD, FL1, BRIARCLIFF MANOR, NY 10510

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