Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other _____

Cardholder Name (as shown on card):_____

Card Number: _____

Expiration Date (mm/yy): _____

CVV: _____ Cardholder Postal Code (from credit card billing address): _____

I, _____, authorize Wilson Wellness and its practitioners to charge my credit card above for agreed upon purchases (which may include but are not limited to osteopathic manual practice, ear acupuncture/seeds, microcurrent therapy, infrared sauna, and other treatments and procedures offered by Wilson Wellness). I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

WILSON WELLNESS

The Woodward Building • 25600 Woodward Ave., Suite #205 • Royal Oak, MI, 48067
248.237.3104 • admin@wilsonwellness.com