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CREDIT CARD REQUEST FORM

This form must be completed if you want us to use your credit card for payment of services.

| 1. | Check One: () This time only for \$ () Always when a balance is due. |
|----|---|
| 2. | I,, authorize Dr. Muriel McClellan |
| | to charge on the following credit card. |
| | () Visa () Master Card () American Express |
| 3. | Name on the Card |
| 4. | Address Credit Card Bill Sent to |
| | ZIP |
| | Email Address (Optional for Automatic Notification) Card Number |
| 7. | Expiration Date/ Month Year |
| 8. | CVV2 Number: The last three (3) digits on the back of the credit card, or 4 digits on the front of American Express |
| | I agree for Dr. McClellan to process charges to the credit card listed above. |
| Si | gnature: Date: |
| | Authorized Card Holder |