



# Credit Card Authorization

The following form authorizes Dr. Kevin Hummel / Valley Wholistic Health Center to process your chiropractic or related health care sessions:

Credit Card:  Visa  MasterCard  American Express  Discover

Cardholder Name: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Security Code (usually last 3 digits on back of card): \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Your Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

You may keep this information on file, strictly confidential, for future use:  Yes  No

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE FAX OR MAIL TO:**

**Kevin Hummel, D.C.**  
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Woodland Hills, California 91367

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