Credit Card Billing Agreement:

I hereby authorize Dr. Rosemary A. Benjamin and the Benjamin Chiropractic & Functional Nutrition Center, P.C. to keep my credit card information on file for future purchases and to charge my credit card for my Chiropractic Healthcare, Functional Diagnostic Nutrition, Metabolic Typing Testing, Hair Tissue Mineral Analysis, Massage Therapy and Nutritional Consulting services.

Client Information

Your name: ___________________________________ Phone: _______________

Your email: ___________________________________ Date: ________________

Payment Information

I authorize Dr. Rosemary A. Benjamin and Benjamin Chiropractic & Functional Nutrition Center, P.C. to automatically bill the card listed below as specified:

- ✓ Amount: $____________________
- ✓ Billing Date :____________________

Credit Card Information

Benjamin Chiropractic & Functional Nutrition Center, P.C. accepts the following credit cards

Your Credit card type: ☐ Visa ☐ Master Card ☐ Amex ☐ Discover

☐ Debit ☐ Credit

Credit card #: ____

Expires: ___________3 Digit Code: ___________

Cardholder's name (as shown on card): ___________________________________

Cardholder's credit card billing address: ___________________________________

City_________________________________State________ZipCode__________

Customer's signature: ____

Benjamin Chiropractic & Functional Nutrition Center, P.C.

Office of Rosemary A. Benjamin, BS, DC, CMTAII, FDN

114 S. 2nd Street, POB 289, Fowlerville, MI 48836

Ph: 517-290-7517 Fax: 231-266-5321 Email: DrRose@BenjaminChiropractic.Com

Website: www.BenjaminChiropractic.com