LEXSTART NUTRITION

Debit/Credit Card Authorization Form

I, (print name)_____ am authorizing LexStart Nutrition, LLC, to keep my signature on file and to charge my debit/credit card ***for chosen services or packages provided as a payment made in full or through chosen payment plans OR in the event that I fail to show for a scheduled appointment without giving 24 hours advance notice.*** I will not dispute any balance due for sessions I have received or for those I have failed to provide 24 hours advance notice of cancellation. Please note your card will not be charged unless these conditions apply. I further authorize LexStart Nutrition, LLC to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Debit/Credit Card

Client Name: _____ Cardholder Name: _____

Cardholder Billing Address (City, State, Zip): _____

Card Type (Visa/ MC/ Amex/Discover) Card #: _____

Exp. Date: _____ CVV: _____

Health Savings Account

HSA Name as Printed on Card: _____ HSA Relationship to Client: _____

Health Savings Account (HSA) Card #: _____HSA Exp. Date _____ HSA CVV: ____

HSA Billing Zip code: _____

Signature of Cardholder (client or cardholder): _____Date: _____

Flexible Spending Account

FSA Name as Printed on Card: _____ FSA Relationship to Client: _____

Flexible Spending Account (FSA) Card #: _____HSA Exp. Date _____ HAS CVV: ___

FSA Billing Zip code: _____

Signature of Cardholder (client or cardholder): _____Date: _____

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