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): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Health Peak Incorporated to charge my credit card above for agreed upon services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

HEALTH PEAK INC.
8000 WESTPARK DR STE 140
MCLEAN VA 22102

TEL: (571) 488-1274
FAX: (754) 218-0642
FAX: (703) 404-2703