CREDIT CARD AUTHORIZATION FORM FOR REPEATING CHARGES

Please complete all areas below:

Cardholder name as it appears on the credit card: _____

Cardholder Billing Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Evening Phone: _____

CARD TYPE (Please Circle One): VISA MASTERCARD

CREDIT CARD #: _____ EXP DATE: _____

SEC. CODE (3 digit number on the back): _____

By signing below, you authorize Birken Medical Aesthetics to charge your credit card on a repeating basis for the procedures performed as reported by you to the Company.

CARDHOLDER SIGNATURE: _____ Date: _____

Randy A. Birken, MD

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