



HEALTH ASSETS[™]
MANAGEMENT

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Authorization to Charge Credit Card (Billing) **Credit Card Update**

Name on Account: _____

Address: _____

Telephone #: _____

MasterCard Visa Discover AMEX

Credit Card #: _____ Expiration Date: _____ CSV Code: _____

Please charge my credit card monthly for billing services

Do not charge my credit card monthly for billing services

Provider/Practice Name

Provider/Practice Signature

Date

Email Address