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ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. I _____,
give permission to have my credit card billed automatically for any outstanding
payments over 30 days. I may also choose to authorize Dr. Gardenswartz to bill
me through my credit card on an ongoing basis. I am aware that Dr. Gardenswartz
adds 3% of charges to all bills.

CLIENT INFORMATION:

Client Name: _____

Email: _____

Address: _____

Phone Number: _____

Credit Card #: _____

Expiration Date ___/___/___

3 or 4 digit security code on back of credit card _____

Please check one the following two options:

Option 1:

Dr. Gardenswartz will use my credit card for unpaid amounts over 30
days. _____

Options 2:

Dr. Gardenswartz will bill me ongoing using my credit card. _____

Client Signature

Date