



## CREDIT CARD PAYMENT AGREEMENT

I authorize, Lea Russell, MBA, RD, LD/N – Nutrition Health Services, LLC to charge my designated card for the amount listed below. This card will be utilized for no other reason unless authorized by card holder.

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_

Please circle type card:    Master Card                      Visa                      \_\_\_\_\_

Number: \_\_\_\_\_ Exp date: \_\_\_\_\_

Address where billing statement is mailed:

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Signature of Cardholder

\_\_\_\_\_  
Date

*Your signature indicates your responsibility for this charge.*

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