Please complete, sign and fax to (561) 658-6212

Credit Card Authorization

• Please complete and sign Section A OR Section B.

A I authorize Andrologix Health and Wellness' parent company Sozo Group, LLC. to keep my signature on file and to charge my credit card account, on an ongoing basis for amounts I owe. Charges will appear on my statement as "Sozo Group, LLC." I understand that this authorization is valid for two years from the below date unless I cancel the authorization through written notice. I also agree to contact the merchant if there are any changes to my credit card account information.

Cardholder Name: ______________________________
FIRST NAME LAST NAME

Cardholder Address: ______________________________
STREET CITY STATE ZIP

If your shipping address is different from your billing address, please enter it here:

Shipping Address: ______________________________
STREET CITY STATE ZIP

Account Number: ______________ ______________ ______________
CARD NUMBER SECURITY CODE EXPIRATION DATE

______________________________ ______________
Card Holder Signature Date

OR

B I don't want my signature on file and understand that I will have to provide my complete credit card information every time I make a purchase or reorder my prescriptions. These purchases will appear on my statement as "Sozo Group, LLC." Andrologix Health and Wellness' parent company.

______________________________ ______________
Card Holder Signature Date

Remember, in order to be considered complete, you must fill-out and sign one of the above sections.