ANDROLOGIX™
HEALTH AND WELLNESS

Please complete, sign and fax to (561) 363-5450

Credit Card 3rd Party Authorization

Patient Name: _____

Address: _____

City/State/Zip: _____

Select the type of credit card you're using:

☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Is this card a:

☐ Personal ☐ Corporate ☐ Rewards ☐ Foreign

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: Month: Year: _____

CVV#: _____

Total Amount $: _____

Credit Card Billing Address:

Street Address: _____

City/State/Zip: _____

I authorize Andrologix Health and Wellness' parent company Sozo Group, LLC. to process my credit card as payment for the patient listed above. I agree to pay the total amount according to the card issuer agreement. The purchase will appear on my statement as "Sozo Group, LLC."

Printed Name: _____

Card Holder Signature: _____ Date: _____