



Aurora Therapeutics, Inc.

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Authorization Form for Credit Card Use

The Undersigned permits and authorizes Aurora Therapeutics, Inc. to keep my credit card information and signature on file. I authorize the charging of my credit card for all fees, for products and services incurred by the below named client, now and in the future.

Today's Date: _____

Name of Client: _____

Date of Birth: _____

Credit Card Type: (Visa/MasterCard) please circle one

Card Number: _____

Expiration Date: _____

3 digit security code (back of card): _____

Name of Cardholder _____

Signature of Cardholder: _____

- I would like to receive newsletters and updates from Aurora Therapeutics, Inc. by email.
- I would like to receive newsletters and updates from the Florida Naturopathic Physicians Association by email regarding wellness topics and state legislation.
- My address, phone numbers, email, or credit card information has changed. (Please see receptionist.)

Email address: _____ (please print)

Credit card information is kept in your confidential chart. Personal information will not be shared.

Thank you!