Credit Card Authorization (Please complete one for each member)

Member Name:	Effective Date:

Cardholder Name (as shown on card):	$_____ Quarterly / Annual Fee (please circle one)*
Billing address for card:	Apt #:

City:	State:	Zip:
Credit Card Number:	Expiration date:	CVV:

(CVV is a 3-digit credit card code usually located on the back of your card on or above the signature line, Amex is the 4 digit code on front of your card)

*The Monthly/Annual Fee is subject to change on 60-days' prior written notice as set forth in the Membership Agreement.

Grayhawk Family Practice is hereby authorized to charge the above indicated credit card on my behalf for the amount reflected above on a recurring basis. I understand that this authorization will remain in effect until I cancel it in writing in the manner described below. I agree to inform Grayhawk Family Practice of any change (including card number, CVV number or expiration date) to my credit card information, which may be required in writing. If I cancel this authorization, I understand that the authorization shall remain in effect for 30 days after the date of my authorization cancellation notice. I also understand that the cancellation of this authorization does not constitute a cancellation of the Membership Agreement. To cancel the Membership Agreement, a completed Membership Cancellation Form must be submitted to Grayhawk Family Practice in accordance with Section 6 of the Membership Agreement.

I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this recurring billing agreement.

To cancel this authorization or provide notification regarding changes in card information, you must notify Grayhawk Family Practice in writing via either:

- **Mail:** Grayhawk Family Practice
  7920 E Thompson Peak Pkwy. Ste 100
  Scottsdale Az 85255

- **Fax:** 480-473-4499

-OR-

- **Email:** NIKKI.KING@GRAYHAWKFAMILYPRACTICE.COM

SIGNATURE (REQUIRED) DATE