



C.A.S.T



Office: 847.825.2278

Fax: 847.825.2279

www.castwellness.com



I, _____, authorize Chiropractic and Strength Training (C.A.S.T.) to charge the credit card listed below for payments for personal training and/or nutrition services. Fees for personal training services rendered at the facility will be charged to this credit card on the 2nd to last Wednesday of each month for the prior month. Fees for nutrition services are charged at the time of the visit.

I agree to update any information regarding this account. The information below is complete and correct to the best of my knowledge.

Credit Card Type: Visa MC AMEX Discover

Credit Card Number: _____

Expiration Date: _____ CVV: _____

Billing Zip Code: _____

Full name as listed on the credit card: _____

Client Signature: _____ Date: _____