NATIONAL ASSOCIATION OF
AFFORDABLE HEALTH CARE

This sheet must be faxed back to our facility at 1-954-692-3963 with a visible copy of your current ID, medical records, and hippa records release form.

I, ____________________ herby authorize NAAHC to charge my credit card for up to one year for services received. The anniversary date for this form, is 12 months from today's date__________

Please print patient name here: ______________________________

Credit Card Information

☐ Visa ☐ M.C. ☐ Discover

Card Number: ____

Billing Address: ____

CVC Number (3-digits on back): __________ Expiration Date: __________

Card Holders Signature: ____

Primary Phone # __________________ Secondary # ________________

Email Address: ____

FAX TO NAAHC 1-954-692-3963 Number of pages _____

If you have any special request or would like to tell us something, use the remanding space below.

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SUPPORT@NAAHC.COM