River Bend Medical Associates
2101 Stone Blvd Suite 190
West Sacramento, CA 95691
(916) 371-4939

Auto Shipment of OmegaHealth
Credit Card Recurring Payment Authorization Form

You are enrolling in River Bend Medical Associates auto shipment program of the OmegaHealth fish oil supplement. Each month you will receive and be charged for a 30 day supply of OmegaHealth if taking as directed.

Please complete the information below:

I _____ DOB: _____ authorize River Bend Medical Associates
patient name
to charge the credit card indicated below on the **second Tuesday** of each month in the amount of $35.00 including shipping and handling costs.

Phone #: _____ Email: _____

Billing Address: _____

City, State, Zip: _____

☐ Shipping address same as billing? If not: _____

Account type (circle one): VISA MASTERCARD AMEX DISCOVER

Cardholder Name: _____ Expiration Date: _____

Credit Card #: _____ CVV*: _____
*3 digit code on back of visa/mastercard, 4 digit code on front of Amex

Signature: _____ Date: _____

I authorize River Bend Medical Associates to charge the credit card indicated in this authorization form according to the terms outlines above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify River Bend Medical Associates if, and when, any changes to account information or termination of this authorization at least 15 days prior to the next billing date. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.