LONGEVITY MEDICAL CLINIC

Feel Younger · Live Better

CREDIT CARD AUTHORIZATION AGREEMENT

I authorize Longevity Medical Clinic to keep my signature on file and to charge my:

○ Master Card ● VISA ○ Discover ○ American Express

Name on Card: PATRICK DEAN HALL

Account Number: [redacted] 4500

Expiration Date: 10/25 CVV/CVC # (Located on back of card) [redacted]

Billing Address: 1616 SE ELLIS COURT #11, PORTORCHARD WA. 98367

I understand that the above credit card will be charged automatically for all charges that apply with this authorization. These include laboratory charges, supplements as needed, autoship supplements, and sermorelin charges. I understand that this agreement is valid unless I cancel this authorization through written notice.

Check all that apply:

- ● Laboratory
- ● Supplements (as needed)
- ● Autoship Supplements
- ● Autoship Sermorelin
- ● All Services

Signature: [signature] Date: 10/15/2020