

Credit Card Recurring Payment Authorization Form

Please complete ALL of the information below:

I _____ / _____ authorize Lunica Beauty, LLC to
First Name Last Name or Business Name

charge my credit card as indicated below as needed for payment of my salon products.

Billing Address _____

Account Type (circle):	VISA	MASTERCARD
Cardholder Name	_____	
Account Number	_____ (Print Clearly)	
Expiration Date	___/___/___	CVV (3-digit number on back) _____
AUTHORIZED USER SIGNATURE	_____	DATE _____

I authorize the Lunica Beauty, LLC to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. 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.

Complete this Form & Send to L'unica Beauty

Fax: (602-788-5043)

text: (602) 900-6444

Email: sales@lunicabeauty.com

via Local Salon Consultant (DSC)