

Date: _____

Modern Back & Neck Clinic
& Weight Loss Center
4041 W. Wheatland Rd. Ste. 120
Dallas, TX 75237
(972) 283-3300

OFFICE USE ONLY:
Copy given to patient by: _____
Patient's initials that agreement was read & a copy was recvd: _____

Amazing Weigh Loss Auto Ship Agreement- Products Only

(Please type or print clearly)

Name: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____

Cell: _____ Wk: _____

Fax#: _____

Products Set \$120.00(Sugar Blocker, Carb Blocker& Turbo Trim)

(Add \$6.99 for auto-shipments)= **\$126.99**

Credit Card Information

Primary: Name on Card: _____

Credit Card Number: _____

Exp. _____ 3- digit CVV: _____

Billing Address: _____

City, State, Zip: _____

Secondary CC#: _____ Exp: _____ CVV: _____

Commitment Period: ___ 6 month's ___ 12 month's ___ 18 month's ___ 24 months

Please circle the month to begin your shipments:

Jan. Feb. Mar. Apr. May Jun. Jul. Aug. Sept. Oct. Nov. Dec.

Please circle the date you would like to have your order processed: 5th 15th 25th 30th

***** **NO REFUNDS** *****

I have been informed about the Wellness Program and I understand the benefits of the Wellness Package that I have selected above. Prices for the Wellness Program have been greatly discounted so a full commitment to the agreed period is essential to the viability of the program. I also understand that my credit card will be billed monthly on the date designated above. Once your commitment period has ended, you may renew, make changes to or cancel your agreement by submitting a written notice 30 days prior to your commitment period ending.

Signature _____

Date _____