



"providing individualized, choice-based care that respects the power or personal connection"

Check/Credit Card Payment

Contact Name _____

Company Name _____

Title _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Charge my credit card (circle one) Amex MC Visa Discover

Account Number _____

Auth Code _____ Exp Date _____ Amount _____

Name as it appears on Card _____

Signature _____

Please Make Checks Payable to: Blue Mountain Clinic

Check Number _____

Amount _____

Mail to: Blue Mountain Clinic
610 North California Street
Missoula, MT 59802