Therapy Solutions
TAKE YOUR LIFE BACK.

CREDIT CARD AUTHORIZATION FORM

Office Use Only
Client ID #______________
Staff Initials______________

Patient Name: ____ **Patient DOB:** ________________________

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

CREDIT CARD INFORMATION

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other_________________________

Cardholder Name (as shown on card): ____

Card Number: ____

Expiration Date (mm/yy): _______ /________

Cardholder ZIP Code (from credit card billing address): ______________________________

I, _________________________________, hereby authorize____________________________________ to charge my credit card for any copays incurred for the patient listed above. I am authorized to use this card and agree to not dispute the transactions, as long as they match the terms. I understand that this authorization allows for regularly scheduled charges to my credit card for the purpose of payment. A receipt will be provided for each payment, and the charge will appear on my credit card statement.

Charges will typically be processed within 1-3 business days after each session. Customers will receive advance notice for changes to the date or amount, but generally not for regular session charges. The authorization remains effective until canceled in writing, with notification required at least 15 days before the next billing date.

____

Customer Signature

____

Date