Credit Card Authorization Form

IMPORTANT: Please read all sections. If you have any questions, please ask before signing.

One-time Payment

- ☐ Bill my credit card once for the following amount $ _____
- ☐ Please apply this payment to the following Invoice #_____

Repeat Payment - Auto Pay Credit Card Program is for clients who want to have their credit card automatically charged for service(s).

- ☐ Per session
- ☐ Weekly
- ☐ Monthly
- ☐ When pre-pay account reaches a zero balance

Credit Card Billing Information

Name: _____ (As it appears on card)

Person Authorizing: _____

Credit Card Type: AMEX VISA MasterCard Discover CareCredit (Please circle one)

Issuing Bank: _____

Credit Card Number: _____ - _____ - _____ - _____

Enter CVC number: _____

Expiration Date: _____ /_____

Billing Address: _____

City, State, ZIP: _____

Phone Number: _____

Email Address: _____

I hereby authorize Peak Potential Therapy LLC to charge the above referenced account and to apply said charges toward the payment of services rendered.

I hereby agree that all information provided is accurate and complete. Further, I acknowledge that services may immediately be terminated at Peak Potential Therapy LLC's discretion if any charges are declined or charge backs are claimed against any outstanding invoiced amount. Disputes to amounts invoiced should immediately be reported to contact@peakpotentialtherapy.com.

I understand that it shall remain my obligation to notify Peak Potential Therapy LLC of any changes in the status of this card, which must be reported to contact@peakpotentialthearpy.com.

_____ _____

Parent/Guardian/Caregiver Signature | Client's Full Name

_____ ____ /____ /_____

Parent/Guardian/Caregiver Printed Name | Date