Financial Agreement and Authorization to Charge Credit Card

• Payments are due at the time of service.

• Any appointments scheduled but not kept, as well as any appointments cancelled within 24 hours of scheduled time will be charged a fee of $100. This is not covered by your insurance company.

Client Name: _____ DOB: _____

Name on Credit Card: _____

Zip Code of Credit Card Billing Address: _____

Phone Number of Cardholder: _____

Credit Card Number: _____

Expiration Date: _____ Security Code/CVV: _____

• I authorize Empowered Hearts Therapy, LLC to charge my card for office charges.

• I understand that if my credit card does not accept the charge, I will immediately make the payment to the practice.

• I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owing will be due & paid in full.

• I acknowledge that credit card transactions could be linked to Protected Health Information.

_____ _____

Signature of Card Holder Date

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