



# Cloud Break Therapy

## Credit Authorization Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Billing Address:

\_\_\_\_\_  
(Street) (City) (State) (Zip)

Please Circle:      Visa / Master Card / Discover

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_      CCV # \_\_\_\_\_  
(3 digits on the back of the credit card)

### Billing Policy

- Your credit or debit card will be charged in the case of a delinquent balance (15 days after an account statement requesting amount due has been sent).
- Your credit or debit card will be charged \$100.00 (not co-pay amount) automatically in the event of a missed appointment or if cancellation occurs less than 24 hours prior to scheduled appointment.
- I understand and accept all of the terms regarding this billing policy.
- I give permission for Cloud Break Therapy, LLC representative to bill my credit card for services rendered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_