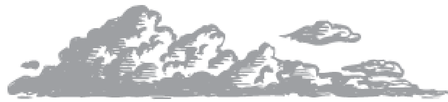

Cloud Break Therapy

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:** ____________________