Life Care Wellness

Caring for Complex Lives - Simply

Credit/Debit Card Authorization Form

Please complete the following information. This form will be securely stored and may be updated upon request at any time. Charges to your card will be listed on your card statement under "Life Care Wellness" or an abbreviation of such.

In case of late cancellation and/or no show for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee. An additional $50 is assessed for returned checks. There is no refund for services rendered.

I, _____, authorize Life Care Wellness to use the information below to charge my credit/debit card in the event:

- **I do not attend a scheduled therapy appointment that I have not cancelled at least 24 hours in advance,**
- **I do not pay any balance due left by myself or my insurance company, or**
- **My check is returned for any reason.**
- **Legal fees, or authorized therapist participation in school or hospital staffings.**

Card Type: *(circle one)* Visa MasterCard Discover

Card Type: *(circle one)* Credit Debit

#:_____ Expiration Date:_____

Name as Printed on Card:_____

Verification/Security Code *(3 or 4 digit code on back of card by signature line)*:_____

Billing Address *(where my credit/debit cards statements are sent)*

Address:_____

City:_____ State: _____ Zip:_____

Phone Number:_____

Signature:_____ Date:_____

By signing below I authorize Life Care Wellness to charge my credit/debit card on an ongoing basis for scheduled appointments.

Signature:_____ Date:_____

(FOR OFFICES PURPOSES)

THERAPIST NAME:_____

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