Your Safe Space, LLC

CREDIT CARD AUTHORIZATION FORM

Name as Appears On Card:_____

Billing Address:

_____

(Street) (City) (State) (Zip)

Please Circle: **Visa / Master Card / AMEX / Discover**
Credit Card Number: _____

Expiration Date: _____CCV:_____

Preferred Electronic Method of Receipts **(Check one)**

o Email: _____ o Cell Phone: _____

Credit Card Authorization Policy

- Your credit or debit card will be charged $30.00 (not co-pay amount) automatically in the event of an appointments cancelled less than 24 hours prior to the scheduled service. In the case of a delinquent account balance (15 days after an account statement requesting amount due has been sent) see Billing Policy Form.
- Your credit or debit card will be charged $100.00 (not a co-payment) automatically in the event of a missed appointment with no notification prior to the scheduled service. In the case of a delinquent account balance (15 days after an account statement requesting amount due has been sent) see Billing Policy Form.
- By providing my contact information I agree that Your Support Service, LLC or representative may send me electronic receipts via Paypal, Square, or email regarding my payments.
- I have read, understand and accept all of the terms regarding the billing policy and credit card authorization policy.
- I give permission for Your Support Service, LLC or representative to bill my credit card for services rendered.

_____

Name (Print) Signature Date