

METHOD OF PAYMENT AUTHORIZATION

This form gives Embrace Healing and Wellness Therapy, LLC consent to charge any financial obligations you may be responsible for including co-pays, co-insurances, deductibles, or any unpaid charges that was not covered by insurance, your flexible spending account or health savings account. Please acknowledge this authorization form by completing the requested information below. This information will be kept on file for future payments. *Please note that you are able to pay via a different method of payment not noted below at any time.* If you choose to do so, please alert the provider at the beginning of the visit to avoid an automatic charge to the existing payment method on file.

Please keep the provider informed of any changes to the method of payment you have on file (including expiration or cancellation of cards, change in banking, etc).

Type of Card: (Please Check One) Mastercard	_VisaDiscoverAmerican Express
Type of Card: (Please Check) Debit	Credit
Card holder's Name:	
Card #:	Expiration Date: CVV:
Billing Address:	
Street	City, State, Zip Code
Authorization (Signature):	Date:
For Health Savings and Flexible Spending Account Holders (This card can not be used for missed visit charges)	
Type of Card: (Please Check One) Mastercard	VisaDiscoverAmerican Express
Type of Card: (Please Check) Debit	Credit
Card holder's Name:	
Card #:	Expiration Date: CVV:
Billing Address:	
Street	City, State, Zip Code
Authorization (Signature):	Date:
By Signing Below, I choose to opt out of the methods of payments above and will pay via cash or check per visit	
Client/Guardian Signature:	Date: