**Unbridled Occupational Therapy**

***Credit Card Payment Authorization***

By this authorization, I agree to allow Unbridled Occupational Therapy, LLC to charge my

Credit Card below for Services Provided. The services may include sessions, late fees, or no

show fees.

Billing Details: Your card will be used to hold your session time and will not be charged until the date of service. Card information is secured and locked. Information is not kept after time of service.

Credit Card Information:

\_\_\_\_\_Visa \_\_\_\_ Mastercard \_\_\_\_\_AMEX \_\_\_\_\_ Discover

Cardholder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Expiration Date:\_\_\_\_\_/\_\_\_\_\_\_\_

Security Code (CVV):\_\_\_\_\_\_

Cardholder’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State:\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_