**ARISE EQUINE THERAPY FOUNDATION File #\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Recurring Credit Card Payment Authorization

You authorize recurring charges to your credit card as services are rendered. You will be charged the amount indicated below and the charge will appear on your credit card statement.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize ARISE EQUINE THERAPY FOUNDATION

 (Cardholder’s Name)

to charge my Credit Card indicated below $\_\_\_\_\_\_\_\_\_\_ per session as services are rendered. \*\*Service Fee of $2.50 per charge will be added for a total charged of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Billing Information

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Card Details

 Visa MasterCard Discover American Express

Cardholder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account/CC Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

CVV \_\_\_\_\_\_

Zip Code \_\_\_\_\_\_\_\_\_\_\_

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify ARISE EQUINE THERAPY FOUNDATION in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form. I understand that charges can occur for confirmed appointments canceled after 24 hours prior to appointment.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Cardholder’s Signature)

 Credit Card Charge Log File #\_\_\_\_\_\_\_\_\_\_\_\_\_

Session Date/Session Time Intake EAP G&L Fee Processed Notes

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