Client Payment Authorization Form

Please complete this form to authorize Thrive Therapeutic Services to process payments for services rendered.

Client Information

- **Full Name:** _____
- **Billing Address:** _____
- **Phone Number:** _____
- **Email Address:** _____

Credit Card Information • **Credit Card Type:** ☐ **Visa /** ☐ **MasterCard /** ☐ **Discover**

Credit Card Number: _____

- **Expiration Date (MM/YY):** _____ **/** _____
- **CVV/CVC Code:** _____ (Last 3 digits on the back of the card)

Authorization Details

I, the undersigned, authorize Thrive Therapeutic Services to charge my credit card for the following purposes:

1. **Service Payments:** I authorize the use of my credit card to process payments for therapy services provided by Thrive Therapeutic Services.
2. **Recurring Payments (if applicable):** I authorize recurring charges for ongoing services as agreed upon, until further notice.
3. **Late Payment / No-Show Fees:** I understand that late payment and/or no-show fees may be applied in accordance with Thrive Therapeutic Services' payment terms.

Terms and Conditions

1. **Payment Authorization:** I understand that this authorization will remain in effect until I provide written notice of its termination, allowing a reasonable time for processing.

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2. **Updating Information:** I am responsible for notifying Thrive Therapeutic Services promptly of any changes to my payment information, including but not limited to expiration date or card number.
3. **Attendance Policy:** I understand and agree to Thrive Therapeutic Services' attendance policy, which may include a fee for missed appointments without adequate notice.

Security Measures

I understand that Thrive Therapeutic Services takes the security of my payment information seriously and employs industry-standard security measures to protect this information.

Client's Signature: _____ **Date:** _____