**CREDIT CARD INFORMATION**

NAME (as it shows on the card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CARD TYPE: Visa\_\_\_\_\_\_ Mastercard\_\_\_\_\_\_ American Express\_\_\_\_\_\_\_ Discover\_\_\_\_\_\_\_\_\_

CARD NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_ CCV: \_\_\_\_\_\_\_\_\_\_ BILLING ZIP CODE\_\_\_\_\_\_\_\_\_\_\_\_

\*\*This information will only be utilized for the sole purpose of collecting a $100.00 no-show or late cancellation fee, unless otherwise specified by this client, as stated and agreed to in the Informed Consent, or for the purpose of collecting an account balance if it should go unpaid by the client for three months or more. This information will remain confidential and secured, in compliance with HIPPA standards. \*\*

\_\_\_\_\_\_ (Initial) I understand and agree to the terms stated in the Informed Consent, indicating this $100.00 fee must be paid in the event of a late-cancel (within 24 hours) or a no-show appointment.

\_\_\_\_\_\_ (Initial) I agree to keep a current credit card in my file, and I understand this credit card will be billed immediately upon a missed appointment without advance cancellation notice.

\_\_\_\_\_\_ (Initial) I understand and agree to allow LKZ Therapy, LLC to charge this card in the event of an unpaid balance on this account for three or more months for the full balance amount.