Breakthrough Therapeutic Concepts, LLC.

836 Ritchie Highway, Severna Park, MD 21146
(410) 670-9048 ✧ info@btconcepts.org

CREDIT CARD AUTHORIZATION FORM

I authorize my provider to keep my signature on file and charge my credit card for payment of my session in the amount established by my provider for the following purposes:

- ☐ For a last-minute cancellation, no-show or missed session without appropriate 24-hour notice (or other appropriate timeframe agreed upon between me and my provider)
- ☐ Co-payment
- ☐ A self-pay session cost (if applicable and discussed previously with provider)
- ☐ Other _____

I understand that my card will be charged **$75** only in the event that I fail to provide sufficient notice of cancellation at the time of my session.

I understand that if I want to use my credit card for my session(s) that I will make a payment at the beginning of the session using the physical credit card.

I agree that this form is valid for the length of therapy and authorization for the use of this card will be cancelled at the termination of therapy.

Client's Name: _____
Card Holder's Name: _____
Card Holder's Address: _____
City: _____ State:_____ Zip: _____
Phone: _____ Email: _____
☐ Visa ☐ Master Card ☐ American Express Acct. # _____
CSC#_____ (3-digit # on back of card)
Signature:_____ Exp. Date: ____/ ____/ ____