



Payment Authorization Form

I, _____, authorize Annie Holscher (dba Artful Aging) to store
[Client Representative] and charge my:

- ☐ credit card ☐ Health Savings Account card
☐ debit card ☐ Flexible Spending Account card

on a recurring basis as payment for therapy services. I authorize use of this card for:

- ☐ Therapy Co-Insurance and/or CoPays
☐ Full Sessions (for clients not using insurance)
☐ Missed session fees (as indicated in informed consent agreement)

Credit Card Information

Card type (select one): ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover
☐ Other: _____

Name (As it appears on the card): _____

Card number: _____

Expiration date (MM/YYYY): _____

***Please note, you will be contacted via the phone number you provided to request for your card CVV in compliance of PCI standards*

I certify that I am the owner or authorized user of the credit card indicated above and will not dispute the scheduled payment with my bank/credit card company; provided that the transactions match with the terms described on this authorization form.

For recurring transactions, I understand that my information will be saved to a secure Electronic Health Records account for future transactions on my account and authorization will remain in effect until I formally request cancellation.

Customer Signature

Date

Billing address: _____ Zip code: _____

Contact number: _____ Email address: _____