



## Life in Balance Therapeutic Healing, LLC.

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### Credit Card Use Consent and Agreement

**Provider Name: Life in Balance Therapeutic Healing, LLC.**

**Patient Name:** \_\_\_\_\_

You are required to have a Credit Card on file to ensure timely collection of payment and any open balances. Please Note: there is a 6.00 charge for credit card transactions.

- I agree to be charged for any open balances accrued in my account with Life in Balance Therapeutic Healing, LLC including Cancellations, No-Shows, Late Payments, Bounced Checks, and other stipulations.
- I understand that should my card be declined when running it for my full balance, that Life in Balance Therapeutic Healing, LLC. reserves the right to run the card in smaller installments until the full balance is paid. Further, I understand and agree to a \$10 charge per declined payment.

I agree to the terms and conditions above:

X \_\_\_\_\_ Date: \_\_\_\_\_

#### PLEASE PRINT NEATLY

Name as appears on credit card:

\_\_\_\_\_

Type of Card:

- Visa
- Master Card
- Discover
- Amex
- Other

Security Code:

\_\_\_\_ \_  
\_\_\_\_ \_  
\_\_\_\_ \_  
\_\_\_\_ \_  
\_\_\_\_ \_

Zip Code:

\_\_\_\_\_

Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

E-mail: \_\_\_\_\_