# Credit Card Authorization

Thank you for your interest in paying for services with your credit card. You may choose to have co-payments, co-insurance, individual sessions, or your monthly statement balance paid by credit card by completing the authorization below. Your completion of this authorization form helps us to protect you from credit card fraud. Treehouse Therapies Associates will keep all information entered on this form strictly confidential and secure.

We hope that this convenient method of paying is of benefit to you. However, if you decide, for whatever reason, that you would like to revoke automatic payments, you may cancel at any time by contacting Alex at 541-389-1848.

I hereby authorize Treehouse Therapies to deduct funds from my credit card account listed below. Please initial:

______ Deduct charges as authorized automatically per my monthly service agreement of $________ per month.

______ Deduct charges as authorized automatically each month for deductible, copayments, and/or co-insurance.

______ Deduct charges as authorized automatically each month for individual services rendered at $______/visit.

I prefer to have payments deducted on ________ (day of month)

***Unless otherwise specified above, your account will be charged the first week of each month for the total outstanding balance.***

Patient's Name: ________________________________________________

Name on Card: ________________________________________________

Credit Card Number: ____________________________________________

Expiration Date: ___________ Security Code: _________________________

Billing Address: ________________________________________________

City: ________________________________ State: _____ Zip: _____________

Phone: ___________________ Email Address: _________________________

Cardholder Signature: ____________________________________________

Print Name: ____________________________________________________

Date: ______________________

**TREEHOUSE THERAPIES Phone: 541-389-1848 Fax: 541-550-7956**
**Physical Address: 2125 NE Daggett Ln Bend, OR 97701**
**Mailing Address: PO Box 1397 Bend, OR 97709**