Transcend Therapy, Inc.
Credit Card Authorization Form

******Completion of this form is a REQUIREMENT for treatment. Please inform your therapist if you are unable to provide us with this information.******

Agreed upon fee or Co-Pay: _____

Name on Card:_____

Card Number: _____

Credit Card Type: Visa _____Mastercard _____AmEx _____FSA/HSA _____

Credit Card Expiration Date: _____

Security Code (back of card, or front of card for AmEx): _____

Billing address including zip code: _____

By signing below, you authorize Transcend Therapy to charge your credit card with any co-pays, unpaid charges (such as bounced checks), late cancellation fees and/or no-show fees ($75.00). You will be notified if your credit card payment is declined by phone, email, mail or text. If your account is not rectified within 5 business days, it may be sent to a collection agency of choice, in addition to the penalties allowed to the maximum extent of the law of the State of California.

- Due to policy changes with our credit card merchant Square Pay, a 3.75% merchant fee will be subtracted from any refunds processed. We sincerely apologize for this, however for each refund transaction that we process, Square no longer refunds the business the merchant fees. We can offer you a credit instead of a refund if you prefer this option.

Client or Parent/Guardian Name: _____

Client or Parent/Guardian Signature: _____**Date:** _____