Please fill in the information and sign below.

Print Name: _____ Patient Name: _____

Phone Number: _____

Email: _____

Credit Card Type [Check One]: ◉ MasterCard ○ Visa ○ Discover ○ American Express

Credit Card Number: _____-_____-_____-_____

Security Code: _____

Expiration Date: ____ /____

Credit Card Holder's Name[print]: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Card Holder's Phone Number: _____-_____-_____

I authorize Happy Hands Therapy Services, LLC to initiate a recurring charge to the credit card indicated above for the total amount due each month / visit. I also authorize charges for any additional related services that I may incur. Charges to my account may vary. I will be provided notice 2 hours prior to the charge occurring on my card.

I understand that I that I may cancel my recurring charge upon written notice to Happy Hands Therapy Services, LLC allowing thirty days(30) time on my cancellation notice.

Card Holder's Signature: _____ Date: _____