



## Credit Card Information Sheet

Name: \_\_\_\_\_

Type of Credit Card:  MasterCard  Visa  Amex  Discover

Name as it appears on the card: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

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

Security Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Best contact phone number: \_\_\_\_\_

Best contact email \_\_\_\_\_

By signing below I agree to charges on this credit card for treatment sessions and late/cancellation fees.

Signature: \_\_\_\_\_

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

**NOTE: Please Print this Filled-Form & Sign it above.**