CHILD'SPLAY THERAPY CENTER

Credit Card Processing Information

Child's Name____

I, _____________________________________, authorize Child's Play Therapy Center, LLC, to charge the following credit card account for merchant services. I also authorize any charges to my card for balances over 30 days. This authorization will be in effect until services have been completed or are ended by request of the client either verbally or in writing.

Card Type: ______________Visa ______________MasterCard

Is this a Flexible Spending Account? __________________________

Card Number: _____________ _____________ _____________ _____________

Expiration Date: ____

Name on Card: ____

Billing Address: ____

____

Phone Number: ____

Email Address: ____

Card Holder's Signature: _____________________________________

Comments: