Arrow Therapy

LETTING GO. MOVING FORWARD.

CREDIT CARD AUTHORIZATION

I authorize Arrow Therapy to charge the following credit/debit card for all fees for services it renders to _____ (name), including a 3% administrative for each credit/debit card transaction.

Credit Card Type: _____Visa _____MasterCard _____AmEx _____Discover

Credit Card Number: _____

Expiration Date: _____ 3-Digit Security Code: _____

Name on Card: _____

Billing Street Address: _____

Billing City, State and Zip: _____

DATE: _____, 201_____.

_____
Client Signature

_____
Client Name Printed

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