Credit Card on File Authorization Card

Please complete this form if you would like THE THERAPY TREE, LLC to keep your credit card on file for future payments. You may elect to provide us with credit card information separately for each payment. All information will remain confidential.

Information to be completed by the card holder:

Cardholder's Name: _____

Client Name(s): _____

Card Number: _____

Card Type: □ VISA □ MasterCard □ Discover □ Care Credit

Expiration Date: _____ Security Code: _____

Billing Address: _____

_____

_____

_____

Email: _____

I, _____, authorize THE THERAPY TREE, LLC to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder's Signature: _____ Date: _____

The Therapy Tree, LLC | 89 Cedar Ave. P.O. Box 764 Lake Villa, IL 60046
ph (847) 265-7300 fax (847) 265-7301
"Growing Together in Mind and Body"
www.thetherapytree.org