Card Type: ____ Visa _____ MasterCard ____Discover ____Amex _____ Other

Today's Date:_________________

Card Number:____

Expiration date:____

Vin code:____

Name as it appears on card:____

Billing address for credit card: Address: ____

City:____________________ State: ________ Zip: ________

I understand the full payment is required at the time of service by either cash or credit card. Payment is also required for missed appointments and cancellations with less than 24 hours' notice. Fees associated with missed appointments and late cancellations can be found in your client handbook.

I also understanding that the financial responsibility for services is mine, and that I must provide any information regarding active insurance to Journey Healthcare.

I understand that if the credit card charge is denied, I will be billed separately for the appointments. I understand that I must pay for any outstanding balance in full before receiving further services.

I agree to call and notify the receptionist in advance of my next scheduled appointment if my address, phone number, or responsible party has changed.

I agree to keep an active credit card on file at all times. I agree to call and notify the receptionist if my credit card expires and will provide a current one prior to my next service.

The undersigned authorizes Journey Healthcare to charge account balances to the above credit card for Services Rendered at Journey Healthcare.

Should any balance be open on your account at time of discharge or discontinued treatment the remaining balance shall be run in full. By signing below, I acknowledge and consent to the use of your credit card without signature on the charge slip, that this agreement will serve as an original and this credit card authorization cannot be revoked.

Cardholders Name (please print): ____

Cardholders Signature:____ Date: ________________