Intermission Therapies, LTD.
22 Crissey, Suite 200
Geneva, IL 60510

Visa/Mastercard/Debit Cards/H.S.A.
Client permission to charge fees to card

I authorize Intermission Therapies, LTD. to process payments on my credit or debit or Health Savings Acc't card for my sessions (for copays, co-insurance amounts, deductibles, and no-show charges.). Charges are generally made within a week of the session. Please make note of the charge at the time of the therapy session per receipt of the super bill. Intermission Therapies is not responsible for overdrafts or insufficient funds in your account.

I understand if my card declines, Intermission Therapies may attempt to reprocess my card on another day when funds become available. After a second attempt is made, the client will be responsible to replace the card information or pay by other means available (cash or check).

I understand that I may revoke my agreement in writing at any time.

Type of card: ____ Visa ____ MasterCard
____ Credit ____ Debit

Client Name: _____

Cardholder Name: _____ Billing Zip Code: _____

Card Number: _____ Security V-code on back: ____

Expiration Date: Month _____ Year _____

Cardholder Signature: _____Date: _____