THE CENTER FOR LIVING BALANCE

130 Governors Square Suite B| Peachtree City, GA 30269 | 770-451-0404

Credit Card Payment Record

Client Name: _____ Name on Card: _____

Email for Receipt:_____ Phone:_____

Card Number: _____

Expiration Date: _____ Security Code: _____ Zip Code: _____

Your signature below signifies your agreement that The Center for Living Balance, LLC, is authorized to make charges to your credit card, per the terms of our signed informed consent agreement. **This includes missed appointment fees equal to the agreed session fee, late cancellation fees equal to your agreed session fee, fees for returned checks, letter writing, form completion, and other incidental charges**. Payment for services does not entitle payor to confidential medical information of other parties.

Signature: _____

Session Date	Posted Date	Amount	Recorder