

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

Credit Card Type: _____ Visa _____ Mastercard _____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

I authorize **Thrive Therapeutic Services, LLC** to charge all balances due and payable to the credit card provided herein. I agree to pay for this service in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

Return the completed and signed form to the following:

Thrive Therapeutic Services, LLC
401 E. Prospect Ave., Suite 214
Mt. Prospect, IL 60056