SUMMIT CENTER

Helping Every Child Reach New Heights

Helping children, adolescents and families realize their potential

CREDIT CARD CHARGE AUTHORIZATION

Date: _____

I, _____, hereby authorize Summit Center to charge the following credit card on a per session/per service basis. I understand that this authorization may be revoked at any time.

Name (as it appears on card): _____

Address_____

_____

Client's Name_____

Credit Card Number: _____

Expiration Date: _____ V-Code: _____ Billing Zip Code: _____

Type of Card: ◯ Visa ◯ Mastercard

Your charges may appear on your credit card as Braintree, Theranest or Summit Center.

☐ This is an FSA or HSA card.

☐ Please mail me a monthly statement. I understand that the statement will contain protected health information.

*if submitting to insurance you will need to request a diagnosis code on your statement.

Printed Name: _____Signature: _____