423 Weathersby Drive Suite 130, Hattiesburg, MS 39402
601-602-3624 • www.acceptedthearpy.com • acceptedthearpy@gmail.com

Credit Card Application

Credit Card Information:	
Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express	
Card Number:	CCV:
Expiration Date:	Billing Zip Code:
Email address for receipt:	

I, _____, understand that payment is due at the time of service, including treatment expenses that are not covered by insurance, such as missed appointments, late cancelations, and co-payments. I will have the option with paying with check, cash, or credit card at the time of service. If I have an outstanding balance or a missed appointment (or other accrued charge), I authorize Accepted Therapy Services to use this credit card information as payment for services as stated in the Treatment Agreement. I also recognize that if my payment cannot be processed Accepted Therapy Services reserves the right to use an attorney or collection agency to secure payment.

_____ _____

Printed Name Signature

_____ _____

Legal Representative Date