LIFE ENRICHMENT CENTER, LLC

2619 W. 6th St, Suite A
LAWRENCE, KS 66049
(785) 842-2752

CREDIT CARD AUTHORIZATION

I authorize the Life Enrichment Center LLC to keep my signature on file and charge my (check one)

VISA_______ MasterCard______ or Discover Card________ for:

______ I will pay by check at each individual session. This credit card authorization is provided as a guarantee of payment and may be used if I fail to make a payment at my session, for returned checks, or at my direction. **(Choose this option if you will be paying at each session by check).**

______ Recurring charges, co-pays, deductibles. **(Choose this option if you would like us to charge your credit card following the receipt of the insurance payment or explanation of benefits).**

I have assigned my insurance benefits to the provider listed above. I understand this authorization is valid for the duration of treatment and 90 days after termination of treatment unless I cancel the authorization through written notice to my provider.

Patient Name: ___________________________________

Patient Date of Birth:_________________

Cardholder Name:____

Cardholder Relationship to Patient:___________________________

Cardholder Address:____

City:____________________________________ State:____________Zip:______________

Account Number:____

Expiration Date: _____________________Security/CCID Coe (3 or 4 digit #):______________

Cardholder Signature:____Date:________________

Email Address: (For Receipts):____