101 S. Whiting St. #204
Alexandria, VA 22304
www.cloudbreaktherapy.com

Payment Authorization Form

Name on Card:

Billing Address:

(Street)

(City) **(State)** **(Zip Code)**

Please Select: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number:

Expiration Date (MM/YY):____/____ **CCV #**____

Terms & Conditions

By completing this form, you acknowledge and accept the following:

- **Payment & Card on File:** An active credit card is required for treatment. Full payment is due for all services, including copays, deductibles, coinsurance, and missed appointments/late cancellations (less than 24 hours' notice).

- **Financial Responsibility:** You authorize charges for the patient responsibility amount determined by your insurance or agreed-upon self-pay rates. Cloud Break Therapy provides cost estimates, but final responsibility is subject to insurance processing. Copays, deductibles, coinsurance, and missed appointment/late cancellations will be charged to your card on the next business day. Any additional patient responsibility, as indicated by your insurance company's Explanation of Benefits (EOB) will be charged to your card upon Cloud Break Therapy's receipt of the EOB.
- **Unpaid Balances:** Future sessions may be suspended after three (3) unpaid sessions. A $50 fee applies to returned checks, and accounts sent to collections will incur a 25% collection fee.

Printed Name

Patient Name (if different than above)

Signature **Date**