NUTRITION THERAPY ASSOCIATES
ELECTRONIC PAYMENT AUTHORIZATION FORM

Please indicate the form of payment you wish to use for any services rendered through Nutrition Therapy Associates. The following forms of payment are accepted: Visa, MasterCard and Discover. This information will be securely stored in your clinical file. Please be aware that transactions will appear as "Therapy Partner" on your credit card statement.

Client Information:

Client Name: ____

Address: ____

City__________________________________ State: __________________ Zip: ________

Account Holder Information:

Please indicate the name and address associated with the credit card you wish to use:

☐ Same as above (if yes, then just add phone numbers)

Account Holder Name: ____

Address: ____

City__________________________________ State: __________________ Zip: ________

Home Number: __________________________ Cell: _________________________________

Credit/Debit Card Information:

Card Type (circle one): Visa MasterCard Discover

Card Number: _____________-_____________-_____________-_____________

Expiration Date: __________________

____ ______________________

Signature of Client or Legal Guardian Date