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628 W. Broadway
Suite 100
N. Little Rock, AR. 72114

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by signing the resending statement at the bottom of this document. This authorization will remain in effect until cancelled or services are terminated.

Credit Card Information					
Card Type:	☐ MasterCard	☐VISA	☐ Discover	☐ AMEX	☐Other ___________________
Please Pay:	☐ Current Balance	☐Monthly Amount: $_____________ *(Not to exceed current balance)*			
Cardholder Name (as shown on card):					
Card Number:					
Expiration Date (mm/yy):					
Credit Card billing address:					
CSV Code (on back of card):					

I hereby authorize ***Nash Therapeutic Services, LLC.*** , and/or its billing designee.
To bill my credit card, as listed above, for charges related to services received. I understand that my information, including credit card information, will be saved on-file for future transactions on my account and any unpaid balances. I recognize that I have the right to cancel this authorization, at any time, by signing the cancellation statement at the bottom of this form which will prevent the use of this credit card for any further charges.

____
Credit Card Owner (Printed Name)

____ ___________________________
Card Owner's Signature or Enter SSN for Digital Signature Date

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I hereby cancel the authorization given to use this credit card as a means of payment for any future charges to my account. I recognize that this cancelation is not retroactive and does not negate the billing of any charges already incurred on my account prior to the signing of this cancelation. I also recognize that the cancellation of this authorization does not negate my right to receive further services or dissolve my responsibility to remit payment for charges acquired.

____ ___________________________
Card Owner's Signature Date