SECOND PHASE Credit Card Authorization

CASA Recovery allows you to pay for services by credit card. The transaction will appear on your credit card statement as CASA Recovery Inc. Fax this signed form back to us in the Intake Department at (949) 284-0574.

Simply fill out the form below and return it with the following:

1. A photocopy of your credit card
2. A photocopy of your drivers license or ID card

Name of Client: _____ DOB: _____ SSN: _____

Program Length: _____ Start Date for Second Phase: _____

Second Phase Program Fee: _____

Payment Terms (What is your understanding of our payment arrangements?):

_____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Name of Cardholder: _____

Billing Address: _____

_____

Email Address (to send receipt): _____

Please indicate you understand the following and sign below:

____ I authorize CASA Recovery to charge my credit card in the amount of $_____. I understand that there is a $750.00 administrative fee should the Client not come to our facility. I acknowledge that this authorization permits CASA Recovery to charge my credit card immediately for the full amount of payment required for services to be rendered to the above referenced client.

____ **I further understand and agree that this transaction is not refundable for any reason including, without limitation, the cancellation of services by me or the client or for the failure of services to produce any specific results with respect to the client.** Therefore, I agree that I will not dispute this charge with my card issuer for any reason, and that this signed statement will be considered final and conclusive authorization for my card issuer to seek payment solely from me for this charge. Furthermore, I recognize and agree that CASA Recovery, Inc. may pursue all available legal remedies directly against the client in the event that I fail to fulfill my payment obligations stated herein.

____ I authorize for this card to be charged immediately for any emergency medications, medical or psychiatric visits, or detox charges necessary during the client's stay.

Authorized Signature: _____ Date: _____

For Administrative Use Approved: _____ Entered: _____