



# Credit Card Authorization

CASA Recovery allows you to pay for services by credit card (Visa, Mastercard, Discover, American Express). The transaction will appear on your credit card statement as CASA Recovery Inc. Please fax this signed form back to us at (949)284-0574 or email intake@casarecovery.com.

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: \_\_\_\_\_

Program Length: \_\_\_\_\_ Arrival Date to Our Facility: \_\_\_\_\_

Program Fee: \$\_\_\_\_\_ Additional Client Spending Money: \$\_\_\_\_\_

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 check or initial to indicate you understand the following sections 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 for any emergency medications, medical or psychiatric visits, or detox charges necessary during the client's stay. I will be notified before this charge is processed.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Administrative Use Approved: \_\_\_\_\_ Entered: \_\_\_\_\_