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I authorize Sari Hands PLC to charge my credit card for the client responsible covered charges (missed visit charges, late cancelation fees) incurred during my course of treatment.

I understand that this information will be held in the strictest of confidence and will be used for the sole purpose described above.

Credit Card Number

Expiration Date/ CVV Code**(3-4 digits)

Full Address/Zip Code

Cardholder Name

Signature

Date
