



Authorization to Bill Credit Card for Services
Recurrent Billing

I _____, authorize SPEECH PATHways to bill my credit card for speech-language pathology services. I understand that my credit card will be automatically billed on or around the first of each month for services rendered in the prior month (or earlier of services are terminated before the end of the month). I understand that I have the right to cancel this automatic payment option at any time. A written request to cancel must be provided to SPEECH PATHways. The recurrent billing will automatically terminate upon the discharge of services.

My credit card information is as follows:

Name on Card

Type of Credit Card (please circle) VISA MASTERCARD DISCOVER

Credit Card # Exp. Date 3 digit CCV#

Address: _____

Please check the type of service your child receives:

- Weekly Treatment (1 hour) – office
Weekly Treatment (1 hour) - pool
Weekly Treatment (1/2 hour) - office
Bi-weekly Treatment (1 hour) - pool
Bi-weekly Treatment (1/2 hour) – office
Bi-weekly Treatment (1/2 hour) – pool
Consultation
Group Treatment – 1 hr \$ _____
Group Treatment – 1/2 hr \$ _____
Specialty Group \$ _____
Other _____

Signature