SPEECH PATHways
Pathways to Communication Enhancement

www.speechpathways.net

Authorization to Bill Credit Card for Services

I _____, authorize SPEECH PATHways to bill my credit card for speech-language pathology services (in office or teletherapy). I understand that my credit card will be automatically billed each week for services rendered (or missed appointments). I understand that I must submit a written request to SPEECH PATHways to cancel this recurring payment plan. 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 AMEX HSA

_____ _____ _____
Credit Card # Exp. Date 3 digit CCV#

Address: _____

Please check the type of service received:

- ☐ Weekly Treatment (1 hour) – in office # of sessions ___
- ☐ Weekly Treatment (1/2 hour) – in office # of sessions ___
- ☐ Weekly Treatment (1 hour) – teletherapy # of sessions ___
- ☐ Weekly Treatment (1/2 hour) – teletherapy # of sessions ___
- ☐ Consultation – in office θ Consultation – teletherapy
- ☐ Group Treatment – 1 hr $_____
- ☐ Group Treatment – 1/2 hr $_____
- ☐ Specialty Group $_____

Client Name _____

_____ _____
Signature of Responsible Party Date

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Shoppes at Meadow Creek
410 Meadow Creek Drive, Ste. 206, Westminster, MD 21158
Clinic: 410.386.0199

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