Authorization for Credit Card Use
All information will remain confidential

Patient's Name: _____

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

I authorize Let's Talk Speech & Language Therapy Services, LLC to charge the weekly co-payment/co-insurance, deductible amount associated with my health insurance carrier, and/or any charges accrued on the patient's account to the above credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

120 West Center St, West Bridgewater, MA 02379 phone (508) 230-8181 fax (508) 230-8182