advantage
speech therapy services

Credit/Debit Card Authorization (*mandatory form)

I authorize Advantage Speech Therapy Services to maintain my credit/debit card on file. I understand that this card will only be used if:

Please check each individual one

- My child's account has been delinquent for more than 30 days and I have not made any effort to make payment arrangements.
  - ☐ Yes
  - ☐ No
- My child's appointment was canceled with less than 24 hours notice.
  ($55 or 50% of insurance rate-per policy form)
  - ☐ Yes
  - ☐ No
- It was a no show for a scheduled appointment.
  ($55 or 50% of insurance rate-per policy form)
  - ☐ Yes
  - ☐ No
- I want to set up automatic payments when an invoice is created.
  - ☐ Yes ****NOTE: There will be a processing fee attached to the use of your card.****
  - ☐ No

_____ _____

Cardholder Signature Date

Patient Name			
Cardholder Name:			
Cardholder Address:			
	city:	state	zip
	Visa _____	Mastercard _____	
Card #		Expiration	CVV