advantage
speech therapy services

Credit/Debit Card Authorization

(mandatory)

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 initial next to each one*

- ☐ My child's account has been delinquent for more than 30 days and I have not made any effort to make payment arrangements.
- ☐ My child's appointment was canceled with less than 24 hours notice.
  ($55 or 50% of insurance rate-per policy form)
- ☐ It was a no show for a scheduled appointment.
  ($55 or 50% of insurance rate-per policy form)
- ☐ I want to set up automatic payments when an invoice is created.
  Only check this box if you want auto payments

NOTE: There will be a processing fee attached to the use of your card.

_____ _____

Cardholder Signature Date

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