RAINBOW SKIES SPEECH-LANGUAGE THERAPY, LLC

CREDIT CARD CHARGE AUTHORIZATION FORM

I authorize Rainbow Skies Speech-Language Therapy, LLC to charge the below-referenced credit card for services rendered and any related expenses (co-pay/co-insurance/deductible or session fee). In addition, I understand my credit card will be charged if:

- I do not pay my invoice in full on the date it is due.
- Proper cancellation procedures are not followed as noted in the Cancellation and No Show Policy.
- A check is returned for insufficient funds (fee of $25.00)
- At discharge, if an account balance remains, your credit card will be charged for unpaid services to discharge date.

I, the undersigned, further understand it is my responsibility to inform Rainbow Skies Speech-Language Therapy, LLC of any changes to my credit card information including address, zip code, updated expiration dates, account numbers and security codes.

PLEASE PRINT CLEARLY; CIRCLE ONE CREDIT CARD BELOW:

VISA MASTER CARD DISCOVER AMERICAN EXPRESS

Account No. _____
Expiration Date: _____ Security Code:_____
Name as it appears on Credit Card: _____

Signature_____ Date_____

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