SeaGlass speech therapy

Credit Card Billing Authorization Form

Billing Information

Name on Card:

Billing Address:

City:

State: Zip: Phone:

Email:

Credit Card Information

Card Type: ☐ Visa ☐ Mastercard ☐ American Express
☐ Discover ☐ Other:

Card Number: Expires:

Billing Authorization

By signing this document, you authorize recurring weekly charges to your credit or debit card. You will be charged each week for the services rendered during that week. A receipt will be emailed to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided.

I, (print full name), agree to the above conditions and hereby authorize SeaGlass Speech Therapy, PLLC to charge my credit card as outlined herein for all services rendered on a recurring basis.

Sign: _____ Date: _____

Please fill out this form, sign and date it, and return it to us either by faxing it to **(888) 977 1542**, emailing it to info@seaglassspeechtherapy.com, or by giving it to the therapist at the time of the evaluation.

SeaGlass Speech Therapy, PLLC
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