Central Texas
Speech Pathology Services, Inc.

PATIENT AUTHORIZATION TO CHARGE CREDIT CARD

I _____ acknowledge that I am responsible for payments to Central Texas Speech Pathology Services, Inc. In the event that my insurance designates co-pays, co-insurance, does not cover billed charges, or the policy lapses, I understand that I am fully responsible for the balance.

I realize that during the course of therapy I may incur the above stated charges, or upon discontinuation of therapy, I may have an outstanding balance due. I hereby authorize Central Texas Speech Pathology Services, Inc. to charge my credit card weekly:

Card Number: #_____ Exp. Date: _____

Cardholder Name: _____ V-Code: _____ Zip Code: _____

I understand that Central Texas Speech Pathology Services, Inc. does not share my credit card information and will mail/email me receipts for these payments.

Patient Name: _____ D.O.B. _____

Signature: _____ Date: _____

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