Payment Agreement and Authorization

(For Private Pay Patients Only)

Authorization

NAME: ________________________________ **PARENT/GUARDIAN NAME:** ___________________________

ADDRESS: ____

____

CREDIT CARD TYPE: _____ Visa _____ MC _____ Discover

CREDIT CARD NUMBER: _____________________________________**EXPIRATION DATE:** _________________

NAME ON CARD: ____**CCV NO. (On back):** ______________

PRIVATE PAY AMOUNT: $200 for evaluation $95 per therapy session

Agreement

I, __________________________ (print name), agree to be responsible for charges incurred in the treatment of ____________________. I fully understand Columbia Speaks, LLC does not submit insurance claims and it is my responsibility to obtain and submit all necessary documentation to receive such reimbursement. I hereby grant permission to Columbia Speaks, LLC to charge the credit/debit card, listed above, for the full amount of each speech therapy session, following each session with the client named above.

________________________________ ______________

Signature of parent/guardian Date