Credit Card Authorization

Client's Name _____

The undersigned authorizes Lapsa Speech Language Center to make the charges to their credit card for payment of speech therapy services and/or associated expenses.

CARD TYPE	VISA	MASTER CARD	AMEX
NAME (as appears on card)			
CREDIT CARD NUMBER			
EXPIRATION DATE			
3 or 4 DIGIT CODE			
BILLING ADDRESS			
BILLING ZIP CODE			

SIGNATURE OF CARD HOLDER

_____

DATE

_____

This information must match the card or it will not process. We request that you notify our office as soon as possible if any of this information changes. This agreement will remain in effect, and your card will be charged weekly, until this agreement is cancelled in writing.

Signature _____

Date _____