KIDSENSE THERAPY GROUP
CREDIT CARD AUTHORIZATION

INSTRUCTIONS: PLEASE COMPLETE AND RETURN THIS FORM PRIOR TO YOUR FIRST VISIT.

Child's Name: _____

AUTHORIZATION TO BILL CREDIT CARD FOR SERVICES

I _____, authorize KidSense Therapy Group to bill my credit card for therapeutic services rendered. I understand that my credit card will be automatically billed on the day services are completed, or the day session installments are indicated (for groups) for my co-pay and/or out-of-pocket charge amount. I understand that I have the right to cancel this automatic payment option at any time with a written request provided to KidSense Therapy Group. The automatic billing will terminate upon the discharge of services and/or once the amount owed is paid in full.

My credit card information is as follows:

Name as it Appears on Card:_____

Type of Credit Card (please check):

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX ☐ FSA/HSA

Credit Card #: _____

Exp. Date: _____

Billing Address:

_____

_____

_____

Person completing form: _____

Relationship to client: _____ Date: _____