Payment Authorization Form

Please provide the following information:

I, _____ *(print cardholder name)* authorize Chesapeake Speech Language Associates, LLC to charge my credit/debit/health account card for professional fees and services for the client, _____. I acknowledge that by giving Chesapeake Speech Language Associates, LLC my credit card information, I will be charged weekly for all copays/coinsurance amounts/out of pocket charges/cancellations fees that are accrued during that time. *I agree to notify Chesapeake Speech Language Associates, LLC of changes to the card or if a new card for payment should need to be added to the account.*

I understand that this authorization will remain in effect until I cancel it in writing and verbal acknowledgement of both parties, and I agree to notify Chesapeake Speech Language Associates, LLC of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. In the case of a transaction being rejected for Non-Sufficient Funds (NSF) I understand that Chesapeake Speech Language Associates, LLC may at its discretion attempt to process the charge(s) again and agree to an additional $35 charge for each attempt returned NSF which will be initiated as a separate transaction for the authorized recurring payment. I acknowledge that the origination of the transaction to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Credit/Debit Card:

Card Type: ☐ Visa ☐ MasterCard ☐American Express ☐ Discover ☐ HSA

Card Holder's Name as it Appears on Card: _____

Card Number: _____ Expiration Date: _____ CVV: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Receipt (if necessary):

If a receipt is needed for your files, please indicate which form of receipt is necessary, and one will be sent weekly to the email provided. If you do not need a weekly receipt, please indicated that one is not needed below, and one can be provided upon request.

☐ I do not need a weekly receipt (no receipt will be provided)
☐ I would like a receipt for the weekly transactions (transaction receipt only)
☐ I need a weekly itemized receipt for insurance/HSA transactions.

Email you would like receipt sent: _____

Patient Name: _____ DOB: _____

Parent/Legal Guardian Signature: _____ Date: _____