Credit Card Form

MUST BE FILLED OUT

Sign and complete this form to authorize Southern Therapy Solutions to make a monthly charge to the credit card listed below. The card will run on the last business day of each month. By signing this form, you give us permission to debit your account for the amount indicated on your monthly statement. This permission for a once monthly transaction and does not provide authorization for any additional unrelated debits or credits to your account. I _____, the parent or guardian of _____, authorize Southern Therapy Solutions to charge my credit card account indicated on my monthly statement. This payment is for Speech, ABA, Occupational Therapy or Dietary Services at Southern Therapy Solutions.

Billing Information:

Billing Address _____

City, State, Zip _____ Phone # _____

Email _____ Card Details: Visa MasterCard Discover American Express

Cardholder Name _____ Account / CC Number _____

Expiration Date _____/_____ CVV _____ Zip Code _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time a month, only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in this form.

Signature _____ Date _____

Initial: ___