12670 Cardinal Woods Drive Pineville, NC 28134
Rebecca Rowe MA, CCC-SLP, Owner
actspeech@gmail.com /704-252-3125

Credit Card/Permission to use and keep on file

Patients Name: _____

Phone Number: _____

Address_____ Zip Code_____

Name of person making payment: _____

_____ I give permission to ACT Speech Therapy, PLLC to bill my credit card which will be
(Initial) kept on file for one year from this date.

Circle type of Credit Card: Visa Mastercard Discover

Credit Card Number: _____ Expiration: _____

*Payment is required on the day of service. In the event that you (the parent/guardian) are not present at the time of treatment, you will be charged by the end of business for the amount due for the day's therapy session. Additionally, if you would like ACT Speech Therapy, PLLC to bill monthly for all sessions, this form indicates monthly billing as well.

By signing this form, it indicates that I have **read** and **fully understand** and agree to the terms listed above.

_____/_____/_____
Signature of Client/Legal Representative **Relationship** **Date**

_____/_____
Signature of Witness **Date**