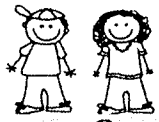

CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

CREDIT CARD AUTHORIZATION FORM

I authorize Creative Speech Solutions, LLC to charge my Credit Card (Visa or MasterCard).

Credit Card Number: _____Expiration Date: _____
CVV#_____

Credit Card Billing Address: _____
City: _____State: _____Zip Code: _____

☐ **Please charge the above credit card on a monthly basis for services and/or copayments. I understand that a receipt will be emailed to me once the card is charged and payments have been applied to my account.**

I acknowledge and understand that the above-referenced is for services rendered on my behalf and at my request by Creative Speech Solutions, LLC. I acknowledge that, by providing this service Creative Speech Solutions, LLC has met its obligations for these charges. In the event that I am more than 60 days overdue in paying my outstanding bill, I give Creative Speech Solutions, LLC consent to charge this credit card. I acknowledge that this agreement may be cancelled with written notice at any time.

I am enclosing copies of my credit card front and back. I agree to provide updated credit card information if this card should expire or be cancelled.

Patient's Name: _____

Name of Cardholder: _____

Signature of Cardholder: _____

Date: _____