

TEGA CAY SPEAKS

PAYMENT INFORMATION AND AUTHORIZATION

YOUR NAME: _____ **CLIENT NAME:** _____
(person responsible for payment)

ADDRESS (INCLUDING ZIPCODE): _____

CREDIT CARD TYPE: _____ Visa _____ MC _____ Discover _____ American Express

CREDIT CARD NUMBER : _____ **EXPIRATION DATE :** _____

NAME ON CARD : _____ **CCV NO. (on back) :** _____

INSURANCE CO-PAY AMT : _____ (*found on insurance card*)

PRIVATE PAY AMOUNT : _____

BILLING AUTHORIZATION : I hereby grant permission to Tega Cay Speaks to charge the above referenced credit / debit card for the full amount of co-payment or private pay amounts as outlined above, following each therapy session with the Client named above.

By signing below, you acknowledge your responsibility to pay Tega Cay Speaks for all approved therapy sessions, agreed upon between Yourself and the Therapist. Tega Cay Speaks will bill your insurance company for the maximum allowable amounts. Amounts not covered by the insurance company for services rendered are your responsibility and payable upon receipt of notice.

The Client(s)' Parent or Guardian, who is hereby responsible for all amounts not paid by insurance:

(Print Name) _____ Date _____

(Signature) _____