www.speechpathways.net

Authorization to Bill Credit Card for Services

Please bill my credit card for services rendered on ______________________________
(Date)

My credit card information is as follows:

____
(Name on Card)

Type of Credit Card (please circle) VISA MASTERCARD DISCOVER

____ ___________________
Credit Card # Exp. Date

____
3 digit CCV#

Address:____

____

Please check the type of service your child received:

- ❑ Weekly Treatment (1 hour) $90.00
- ❑ Weekly Treatment (1/2 hour) $60.00
- ❑ Group Treatment $____________
- ❑ Other _______________________________________

Total to be billed to your credit card $______________________

____
Signature

Westminster Clinic
Westminster Professional Center
532 Baltimore Blvd., Ste. 403, Westminster, MD 21157
Clinic: 410.386.0199

Business Office
4127 Falls Road, Manchester, MD 21102
Office: 410.374.0555 Fax: 410.374.8620