Credit Card Authorization Form

Client Information
Child's Name: _____
Parent/Guardian Name: _____
Phone Number: _____
Email: _____

Cardholder Information
Name on Card: _____
Billing Address: _____
City: _____ State: _____ ZIP: _____
Phone Number: _____

Card Details
🔘 Visa 🔘 Mastercard 🔘 American Express 🔘 Discover
Card Number: _____ _____ _____ _____
Expiration Date (MM/YY): _____ / _____
CVV: _____

Authorization

I authorize **Hand in Hand Therapy** to charge the credit card listed above for:

Occupational therapy evaluations and treatment sessions
Missed appointments or late cancellations (per clinic policy)
Any outstanding balance on my account

Charges will only be made with prior notification or in accordance with clinic policies that I have received and reviewed.

I understand that this authorization will remain in effect until I cancel it in writing. I also understand I may request a receipt for any charges at any time.

Signature: _____ **Date:** _____