HAND IN HAND THERAPY

Guiding little hands. Growing big skills.

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

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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.

Legal Guardian Printed Name: _____

Signature: _____ Date: _____