BOOST Kids
PEDIATRIC THERAPY

Credit Card Authorization Form

BOOST Kids holds a client credit card on file to charge for all patient responsibility payments, including: co-payments, co-insurances, deductibles, private pay payments, no-show fees, etc. We do NOT accept cash or check payments in the BOOST Kids office. Patient responsibility payments are due at the time of service, and will be made via the credit card listed below through a secure HIPPA compliant and PCI secured system. You will be emailed a receipt for every transaction billed to this card.

Please provide the credit card information you would like your patient responsibility payments to be billed to. Payments are typically charged within 24 hours of your appointment. Please notify us in writing or request a new credit card authorization form if you would like to change your primary method of payment at any point in the future. Failure to update your billing information in a timely manner, that prevents charges from being applied to your account, will result in a $20 administrative fee. Thank you!

Client (child's) Name: _____

Cardholder Name: _____

Relation to client: _____

PLEASE FILL IN ALL REQUESTED INFORMATION BELOW AND ATTACH A COPY OF YOUR CREDIT CARD AND DRIVER'S LICENSE

CARDHOLDER'S NAME: _____

CREDIT CARD BILLING ADDRESS: _____

City: _____ State: _____ Zip Code: _____

CREDIT CARD: Mastercard___ Visa ___ American Express ___ Discover___

CREDIT CARD NUMBER: _____

EXP.DATE: _____ CVV#: _____

PHONE NUMBER: _____ DRIVER'S

LICENSE NUMBER: _____ STATE: _____

I hereby authorize BOOST Kids to charge my credit card account for all patient responsibility payments not paid via check at the time of service.

Card Holder's Signature: _____ Date: ___/___/____