



CREDIT CARD AUTHORIZATION FORM

Name on Card:	
Credit Card Type:	VISA MASTERCARD DISCOVER
Credit Card Number:	
Expiration Date:	
CVC:	
Billing Address:	

I understand any outstanding balances still remaining after 30 days of the last date of service will be charged to the card/account provided, and I completely understand the financial policies outlined in the client handbook.

I authorize Social Connections to charge my credit card/account provided for all ABA therapy charges/patient responsibility according to your plan's benefit, and all attendance related fees. The final bill will be charged immediately upon discharge, for any claims that may be outstanding or in process at the time of discharge, and all attendance-related fees will be charged as they occur.

I understand that in the event that my credit card is declined, there will be a \$75.00 penalty fee added to my bill and my credit card will be billed until payment is received for outstanding invoices.

Please make sure you refer back to the attendance policy for clarification on the fees associated with late drop offs/pick ups (after five minutes), cancellations without proper/timely notifications, etc.

Social Connections is always ready to assist you with any additional questions or concerns you may have. You can reach the appropriate personnel by phone at (281) 799-1744

Responsible Persons Print Name

Responsible Persons Signature

Date

I, _____ (FULL NAME), authorize Social Connections to charge my bank account indicated below for ABA therapy and/or all other attendance charges will be charged as they occur.

This payment is for ABA therapy patient responsibility, tardies(after five minutes past scheduled session start time), early departures, and cancellations without proper notice.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Social Connections in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ **DATE** _____

(Account Holder's Signature)