CREDIT CARD AUTHORIZATION FORM

I have provided My Kids Therapy with a credit card to keep on file for the use of charges associated with occupational therapy services. I understand that these payments will be processed through a secured payment processing system. I authorize the provided credit card/debit card to be charged for the copays, coinsurances, or deductible amounts predetermined by my health insurance policy and/or the out-of-pocket agreement on file with My Kids Therapy. If I need to make changes to the card on file or the amount to be charged, I am responsible for contacting My Kids Therapy to make these necessary changes.

Parent/Cardholder Name:_____
Last 4 digits of Card on File: __ __ __ __
Parent/Cardholder Signature:_____
Date:_____

Patient Name:_____