Kid O' Therapy, LLC
41 Main Street
Topsham, Maine 04086
P: (207) 844-8287
F: (207) 844-8245
www.kidotherapy.com

AUTOMATIC BILLING AUTHORIZATON FORM

Company Name: Kid O'Therapy, LLC **Email**: _____

Child's Name: _____

FROM CREDIT CARD:
I authorize you to charge my bill directly to the credit card(s) listed below:
(A second card is required in case the first card is denied)

Primary Card Account:	Secondary Card Account:
_____ Name on credit card (exactly as printed)^	_____ Name on credit card (exactly as printed)^
_____ Billing address for credit card (Street, apt #)^	_____ Billing address for credit card (Street, apt #)^
_____ City, State, Zip^	_____ City, State, Zip^
_____ _____ Credit Card Number^ Expiration Date^	_____ _____ Credit Card Number^ Expiration Date^
_____ _____ Signature^ Today's Date^ CVC _____	_____ _____ Signature^ Today's Date^ CVC _____

X By signing this form, I authorize all charges to the above cards to be charged per visit. This includes co-payments, co-insurances, deductibles, and any outstanding balances. I will receive written notification.

X I authorize $_____ per visit to be applied towards my outstanding account balance in addition to my co-pay.

x This authorization is valid until I provide you with written cancellation.