Anderson-Smith
SPEECH THERAPY LLC
Play with Purpose

6100 West 41st St, Suite 102
Sioux Falls, South Dakota 57106
jessica@andersonsmithspeech.com
605.271.1852JGROENEVELD7

**CREDIT CARD AUTHORIZATION FORM**

It is the policy of Anderson-Smith Speech Therapy that a credit card be kept securely on file for the following reasons:

- **Outstanding Balance**: If your insurance provider has paid their portion of your bill and there is still an outstanding balance owed, Anderson-Smith Speech Therapy will notify you in writing. If you have an outstanding balance past 60 days, your card will be charged for the outstanding balance within 15 days, if you do not call our billing department to make partial or full arrangements for payment. A copy of the charge will be mailed to you upon request.

- **Missed Visits:** If you miss an appointment without giving a 24-hour notice, your card will be charged a missed visit fee. This fee cannot be submitted to insurance. Last minute cancellations (i.e., less than twenty- four hours before the designated appointment) will be billed at $50 per session. No calls/No shows will be billed in full for the treatment session missed. A receipt will be provided upon request. Please write legibly. Please double check the numbers you've written to ensure correct information is given. I authorize Anderson-Smith Speech Therapy to make charges to this credit card for payment of speech therapy services and/or other services and fees. I understand that this authorization will remain in effect until I cancel it in writing, or until my child is no longer receiving therapy services. I agree to notify Anderson-Smith Speech Therapy in writing of any changes to my credit card information or termination of this authorization at least 5 days prior to my child's therapy session. I certify that I am an authorized user of this credit card. I recognize that Anderson-Smith Speech Therapy agrees that my credit card information is private and protected, and will be treated as such.

• **Co-Pays/Co-Insurance:** Payment is due at time of service, including all co-payments, co-insurance, and deductibles. You may pay by cash, check, or a credit card different from the credit card on file.

• **Other Services and Fees:** Private Pay services, co-pays/co-insurances, no-show, late cancellation and other fees are due at the time of the office visit.

**In providing your credit card information, you are giving Anderson-Smith Speech Therapy permission to automatically charge your credit card on file for your co-pays/co-insurance, missed visits and/or Private Pay services that are not paid for at the time of service, and for any outstanding balance past 60 days from written notification.**

| **Credit Card Information** | |
|---|---|
| **Credit Card Number:** | |
| **CVV (3 digits):** | **Expiration Date:** |
| **Name as printed on card:** | |
| **Billing zip code:** | |

***Please write legibly. Please double check the numbers you've written to ensure correct information is given.***

Credit Card Holder's Signature: _____

Date: _____

I understand that this authorization will remain in effect until I cancel it in writing, or until my child is no longer receiving therapy services. I agree to notify Anderson-Smith Speech Therapy in writing of any changes to my credit card information or termination of this authorization at least 5 days prior to my child's therapy session. I certify that I am an authorized user of this credit card. I recognize that Anderson-Smith Speech Therapy agrees that my credit card information is private and protected, and will be treated as such.

Signature:_____Date:_____