

P3: Payment Authorization Form

Client Name: _____ Parents: _____

Client DOB: _____ Address: _____

Phone: _____

Cardholder authorizes payment of services to Achieve Pediatric Therapy and agrees to comply with the obligations set forth in the Cardholder agreement with the issuer. Cardholder authorizes payments to be charged to the card indicated below:

Registration Fee in the amount of \$50.00- to be paid on or before May 15, 2015

Balance of Registration Fee in the amount of \$70.00- to paid on the first day of Class- June 16, 2015

Full Registration Fee- in the amount of \$120.00- to be paid on or before May 15, 2015

Credit Card Type: Visa MasterCard Discover

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Cardholder Name: _____ Payment Amount: _____

Cardholder Signature: _____ Date: _____

Achieve Pediatric Therapy