Star Therapy
Pediatric Therapy for Rising Stars

PRE-AUTHORIZED CREDIT CARD PAYMENT FORM

I, _____ authorize Star Therapy, Inc to keep my signature on file and charge my credit card account for:

- Charges for services attended
- Insurance co-payment of $_____ at time of each session and additional fees in the event insurance does not pay. (This only applies to insurance companies with whom we contract and includes missed appointments)
- Charges for missed appointments (no shows or not cancelling within 24 hours of appointment)
- Balances for charges not paid within 90 days

Star Therapy, Inc agrees to only charge for the above circumstances and to keep my credit card information confidential.

CREDIT CARD INFORMATION:

Credit Card: (please circle one) **M/C** **Visa** **Amex** **Discover**

Credit Card Number: _____

Expiration Date: (month)_____(year)_____

Credit Card Bill To Address: _____

City /State: _____

Bill To Zip Code: _____

Signature Panel Code: _____

We request that you notify our office as soon as possible if any of this information changes. This agreement will remain in effect, and your card may be charged monthly, until this agreement is cancelled in writing.

_____ _____

Signature Date

754 Night Fire Drive, Dawsonville, GA 30534
www.startherapyga.com Phone 404-514-4990 Fax 404-759-2973