Authorization for Billing Card on File

The Aubin Aphasia Speech and Language Center LLC requests that patients provide an active credit or debit card to be kept on-file. Invoices for services are provided monthly. If the balance remains unpaid 30 days after the date of the invoice, then this card will be used to pay that balance. Each time your credit card is used to pay for services, a 3% convenience charge will be applied. Your card information will be kept confidential and secure.
If you choose not to have a card on-file, a $5.00 charge will be added to your account to cover the administrative work of resending the monthly statements. In addition to this $5.00 administrative charge, a late fee of 1.5% of the total bill will be charged for each month the balance is unpaid.

I, _____, authorize The Aubin Aphasia Speech and Language Center LLC to charge the portion of my bill that is my financial responsibility to the following credit or debit card, according to the terms above:

Card Number _____ Exp. Date _____ CVV: _____

Visa ☐ MC ☐ Discover ☐

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State _____ Zip _____

I , _____, the undersigned, authorize and request The Aubin Aphasia Speech and Language Center LLC to charge my card, indicated above, for balances due that are my financial responsibility. I may cancel this authorization with a 14-day notification to The Aubin Aphasia Speech and Language Center LLC in writing and understand my account must be in good standing.

Patient Name (print):
_____

Responsible Party: _____

Patient or Party Signature:
_____ Date: _____ / _____ / _____