A Speech Connection Clinic

AUTHORIZATION FOR CREDIT CARD PAYMENT

Type of card:

CARD HOLDER NAME: _____

CARD NUMBER: _____

BILLING ADDRESS: _____

_____

EXPIRATION DATE: _____ **CVC #:** _____

I authorize A Speech Connection Clinic to charge the credit card listed above for Speech services on the date that services are rendered.

_____ **DATE:** _____

Card holder signature