



Credit Card Authorization Form

In order to provide you and the other patients of Leaps and Bounds the best possible care, we ask that you reschedule or cancel your appointment **before** your scheduled appointment time.

I, _____, understand the importance of notifying Leaps and Bounds prior to my scheduled appointment if I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible. I understand that I will be charged a No Show fee of \$10 for **failing to call and failing to show** for my scheduled appointment.

I, _____, give Leaps and Bounds the authorization to charge my credit card \$10 for each missed therapy session where I **fail to call and show** for the appointment. I will be provided a receipt for all payments upon request.

Leaps and Bounds is an **out-of-network provider**. This means that insurance checks may be mailed directly to your home. We receive information that you have been paid and expect you to bring payments to your next session.

I, _____, give Leaps and Bounds the authorization to charge my credit card for dates of service that have been paid for where checks were not remitted to the office.

I am requesting that this card also be used for payment of services or co-pays: Yes ___ No ___

Name on card: _____

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ Code: _____

Street Address: _____ Zip Code: _____

Email address for receipt (optional): _____

Patient Name (printed): _____

Parent/Guardian/Card Holder Signature:

_____ Date: _____