Bloom Pediatrics

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Email: bloompediatrictherapies@gmail.com

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting our office. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type:
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Billing Zip Code for Card:
Security Code (3 digits on back):

I, _____, authorize Bloom Pediatrics (Blooming Pediatric Therapies, Inc.) to charge my credit card above for transactions related to therapy services provided. I understand that the cost of speech therapy sessions is approximately $99.69 per session and occupational therapy sessions are approximately $128 and that I will be charged for sessions conducted following completion of each session. I understand that the information provided on this form will be secured in a protected, HIPAA compliant file for future transactions on my account, and while the information is unlikely to be tampered with, I agree to assume the risk if the credit card information were to become compromised.

_____ _____ Customer Signature Date