Big Sky Pediatric Therapy

Credit Card Authorization

Credit Card Billing Information:	
Name on Card	
Patient Name	
Credit Card Type	
Credit Card Number	
CVC Number	
Expiration Date	
Email Address for Receipt	
Billing Address	
State	
Zip Code	
Phone number	

Client agrees that all information provided is accurate and complete

Client authorizes Big Sky Pediatric Therapy to charge any outstanding balances to the credit card number provided. We will contact you before charging a balance over $250.

Authorized signature_____

Date_____