

Whole Kids Therapy

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PAYMENT CONTRACT

Patient Name: _____

Mailing Address: _____

Whole Kids Therapy requires treatment fees to be paid by the last day of each month. Please initial one of the following payment methods:

_____ I, the undersigned, hereby acknowledge and agree to pay treatment fees by the end of the month either by personal check, cash, or credit card. Please make checks payable to Whole Kids Therapy.

_____ AutoPay: I, the undersigned, hereby authorize Whole Kids Therapy to charge my credit card entered below each month to pay for (child's name): _____ therapy sessions. I agree that my credit/debit card will be charged the amount as stated on or after the last day of each month. I will receive a monthly statement within 10 business days of the charges. I have the right to dispute any part of the bill within 30 calendar days of the closing of the month, after 30 days I will not dispute any part of the bill. If a credit/debit card company rejects automatic payments and reverses charges, Whole Kids Therapy will charge a return fee and any other costs associated with the charges.

_____ I have the right to cancel my AutoPay authorization with written notification to Whole Kids Therapy at any time.

Please check card type: Visa MasterCard

Card Number: _____ Expiration Date: _____ CVS# _____

Card Holder Name: _____

Authorization Signature