5454 Wisconsin Avenue
Suite 1555
Chevy Chase, MD 20815
Phone: 301.951.8593
Fax: 301.951.8598

2021 K Street, NW
Suite 610
Washington, DC 20006
Phone: 202.540.5999
Fax: 202.540.5690

5215 Loughboro Road, NW
Suite 200
Washington, DC 20016
Phone: 202.787.5620
Fax: 202.787.5606

Credit Card Payment Authorization for Minors

In the event that a parent or legal guardian will not be able to attend therapy sessions with a patient that's a minor, a credit card may be left on file with the business office. Please note that this form authorizes SMARTherapy to process **encounter fees ONLY**. If you wish to authorize payments for outstanding balances please notify the billing office.

Please sign the form below if you would like to set up automatic payments to cover the encounter fee. If you have any questions please feel free to ask the front desk staff, or contact our business office Monday – Friday, 9:00am – 5:00pm at (301) 657-3465

Patient Name: ____

Account Number: ______________ DOB: ________________

Encounter Fee: ______________

Cardholder Name: ____

Card Type (Please Circle) VISA MASTERCARD AMEX

Credit Card #: ____

Expiration Date: ________________ Security Code (on back): ________

If you would like your receipt emailed please provide your email below

____

☐ I hereby authorize Smartherapy to charge this credit card listed above in the amount specified. I understand my card will be charged within 48 hours of each of my child's therapy appointments and no prior notification will be provided. My signature below confirms my knowledge and acceptance of the encounter fee mentioned above.

Cardholder Signature: ____

Date: ________________