CREDIT CARD AUTHORIZATION

12919 S. 86th Avenue
Palos Park, IL 60464
Phone: 708-231-8901
Fax: 312-277-2544
notredamefamilycenter@comcast.net

Thank you for allowing us to provide your family with therapy services. *If you would like to pay your co-payment or pay for our services in full with a credit card, your prior authorization is required. While your information will be stored securely in your patient file in accordance with our privacy policies, you assume the risk of allowing this information to be kept on file and of transmitting it to us by fax or mailing it to us for invoice payment. Payment is normally due at the time services are rendered. If your account is in arrears, your credit card will be charged for the full amount due invoiced, including any associated fees and taxes, unless you specify a lesser amount to be paid in accordance with a payment plan approved by our billing department. Your authorization remains in force until withdrawn by you in writing or until the termination of therapy services.*

Credit Card Authorization:

Name of Client (Please Print): _____

Name of Cardholder (Please Print):_____

Type of Card:

- ❑ **MasterCard**
- ❑ **Visa**
- ❑ **Discover**
- ❑ **American Express**

Card Number: _____

Expiration Date:_____

CVV Code:_____

Billing Zip Code:_____

I certify that I am the authorized holder and signer of the credit card referenced above and that all information provided is complete and accurate. I hereby authorize collection of co-payment or payment for services provided by Notre Dame Family Centers, Inc., at the time service is rendered. I understand that there is an additional 5% convenience fee on all credit card transactions.

Cardholder Signature: _____

Date: _____