Therapy Links, Inc.

Patient Easy Pay Consent Form

For your convenience we offer the following payment options:

Patient Name: _____
Last First Middle

I authorize: **Therapy Link, Inc.**

To charge my payment card: Please select an option below

_____ Monthly/Statement by mail

_____ Weekly/In person

_____ Credit Card on file/Monthly – We will make copy of credit card.

I understand this form is valid for one year, unless I cancel the authorization through written notice to the health care provider.

____/____/____ _____
Today's Date Parent Signature