Whole Kids Therapy

wholekidstherapy.com
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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 or cash. Please make checks payable to Whole Kids Therapy. If by the 10th of the following month payment is not received, the credit card you provide below automatically charged.

Please check card type: ☐ Visa ☐ MasterCard

Card Number: _____ Expiration Date: _____CVS# _____

Card Holder Name: _____

_____
Authorization Signature