CENTER OF
DEVELOPMENTAL
PEDIATRICS

AN OCCUPATIONAL THERAPY CLINIC

Automatic Credit Card Billing Authorization Form

Cardholder Name: _____

Phone Number _____

Card Type: Mastercard / Visa / Discover

Card Number: _____

Expiration Date: _____ 3 Digit Code: _____ (Found on back of card)

Credit card billing address: _____

Email Address: _____

Patient Name: _____

I authorize Center of Developmental Pediatrics, LLC to automatically bill my credit card listed below as specified:

Amount: $_____. (or 'As billed')

Cardholder Signature_____

Please contact our billing office for any questions or concerns:

Office: (713) 977-0730 / Dianna Sutter (832)865-4329 / Email: cdplocations@gmail.com