AAF-The Sensory Pathway
399 Ridge Road m Suit 4 & 5, Dayton NJ 08810 • TEL (815) 66A-KHIL
programs@akhilautismfoundation.org

CREDIT CARD AUTHORIZATION FORM

Credit Card Information *(choose One)* ***VISA - MasterCard –American Express***

Credit Card Account #: _____ Exp Date: _____

Security code (if applicable) _____

Billing Information

Name _____

Cardholders Billing Address: _____
(No PO Boxes Accepted)
City: _____ State _____ Zip _____

Phone Number: _____

Fax Number: _____

I _____ (name of card owner) authorize **The Sensory Pathway** to charge the above credit card at the end on each month for services rendered which may include: **Occupational Therapy** And, I guarantee payment for any charges made with the credit card account number identified above, including renewed cards

_____ _____
Signature of owner *Date*

Print Name_____

** The Sensory Pathway will provide a receipt for all credit transactions.