1815 NW169th Place, Suite 3070
Beaverton, OR 97006
Ph 971-249-2653
Fax 503-747-4373

BOLD Pediatric Therapy Center

Credit Card Payment Agreement

Client Name _____

Date of birth _____

I give permission to BOLD Pediatric Therapy Center to hold my credit card on file and to bill this card for outstanding payments owed.

This agreement will be in effect from the date of signing or until BOLD Pediatric Therapy Center receives a written notice of change.

Credit Card number: _____

CVV: _____ exp date: _____ Billing zip code: _____

Signed: _____

Relationship: _____

Date signed: _____