LAKESHORE
SPEECH THERAPY, LLC.

LAKESHORE SPEECH THERAPY PRIVATE PAY

PATIENT INFORMATION

Patient Name	
Zip Code	

CREDIT CARD INFORMATION

Card Holder's Full Name	
Credit Card Number	
Expiration Date	
CVC Number (3 digit on back/4 digit on front)	

FINANCIAL OBLIGATION

I, _____, as parent/guardian/card holder, acknowledge I will pay for speech therapy services without insurance. Private payments will be required at the time of each service.

Signature	Date