



LIGHTHOUSE PROJECT

*Providing Occupational and Speech Therapy Services for Children with Unique Learning Needs
Specializing in the Treatment of Asperger's, NLD and HFA*

Lighthouse Project Payment Contract

Child's Name: _____

Mailing address: _____

Lighthouse Project requires treatment fees to be paid at the time of each treatment. Please initial one of the following payment methods:

I, the undersigned, hereby acknowledge and agree to pay treatment fees at the time each treatment is provided either by personal check, cash, or credit card.

**** Please make checks payable to Lighthouse Project.**

AutoPay: I, the undersigned, hereby authorize Lighthouse Project to charge my credit card entered below each month to pay for **(child's name):** _____ monthly therapy sessions. I agree that my credit /debit card will be charged the amount as due stated on the monthly statement on or after the last day of each month. I will receive a monthly statement within 10 business day of the charges. I have the right to dispute any part of the bill within 30 calendar days of the closing of the month, after 30 days, I will not dispute any part of the bill. If a credit/debit card company rejects automatic payments and reverse charges, the Lighthouse Project will charge a return fee and any other cost associated with the charges.

I have the right to cancel my AutoPay authorization with written notification to the Lighthouse Project at any time.

Please check card type: Visa MasterCard American Express

Card Number: _____

Expiration Date: _____ CVS# _____

Card Holder: _____

Authorization:

Signature

Print name

Date