

Alaska Speech & Hearing Clinic
2401 East 42nd Avenue Ste #101
Anchorage, AK 99508-5228
(907) 562-4550 / (907) 562-4554 – Fax

Date_____

Patient Name_____DOB_____

I give Alaska Speech, Hearing & OT Clinic permission to charge my credit card with the

- Balance of Account \$_____
- Payment on Account \$_____ Each Month Yes___No___
Balance after Payment \$_____
- Charge Co-Pay each Appt \$_____

My account is with_____MasterCard/Visa/American Express/Discover

Account #

Expiration Date

Signature of Cardholder

Phone #

Print Name (Shown above)

Address of cardholder

City, State of cardholder