Terms and Conditions

The group session prorated fee is $300 per child and includes ten (10) 1-hour sessions.

Dates of sessions include:

- September 11th
- September 18th
- September 25th
- October 2nd
- October 16th
- October 23rd
- October 30th
- November 6th
- November 13th
- November 20th

Consistent attendance is extremely important for your child to obtain maximum benefits from group. **You are financially responsible for all sessions, even if your child is unable to attend. All payments are non-refundable.** Social skills groups are not therapeutic services; therefore, they are not billable to your insurance. Any questions or concerns should be directed to ffoster@autismacademyofsc.org.

Please select one of the following payment options:

☐ **Early Registration: Full payment of $270 due by September 4, 2017. (Includes 10% discount)**

Please check one of the following payment options

- Check # _____ *(Please make checks payable to the Autism Academy of SC. *$35 returned check fee*)*
- Credit Card – (*please complete credit card information below)*
- Cash

☐ **Payment in Full: $300 payment in full due by September 11, 2017**

- Check # _____ *(Please make checks payable to the Autism Academy of SC. *$35 returned check fee*)*
- Credit Card – (*please complete credit card information below)*
- Cash

☐ **Installment Plan: Three $100 automatic credit/debit card payments payable on the 1st of each month**

If paying via credit card, please complete the credit card authorization form.

GENERAL AUTHORIZATION:

My signature below indicates that I have read this agreement and agree to all its terms.

Printed Name: _____

Signature: _____ Date: _____

Credit Card Information

Credit card type: ____Visa ____ MasterCard ____ Discover

Payment Option **(select one):** __$270 one-time fee __$300 one-time fee ___ $100 Monthly Installment

Client Name: _____

Card Holder Name (as shown on credit card): _____

Credit Card #: _____-_____-_____-_____ **Expiration Date:** _____/_____
MM/ YY

Billing Address of Credit Card Holder: _____
Street address

_____ _____ _____
city *state* *zip*

This agreement will be in effect from: 9/4/17-11/20/17

Credit Card Authorization *(if applicable):*

- I hereby authorize the Autism Academy of South Carolina (AASC) to charge the indicated credit card on a periodic basis to collect payment due for services rendered by AASC in accordance with the AASC Fee Schedule for the above listed client.
- I also authorize AASC to charge my credit card for the full cost without regard to my child's attendance.
- If AASC is unable to process my payment, I will be responsible for making an alternate payment arrangement prior to my child attending any sessions.
- I understand that this agreement shall remain in force for the dates listed above.
- I guarantee and warrant that I am the legal cardholder for this credit card and that I am legally authorized to enter into this agreement with AASC.

Printed Name: _____

Signature: _____ Date: _____