Spectrum Speech Pathology Services Pty Ltd

Remmitance / Payment Advice

Your child's name: _____

Payment for (Invoice Ref if any) _____ by: (tick one)

⌜ Chq / Money Order for $ _____ enclosed

_____

⌜ Direct Transfer to our account**: Spectrum Speech Pathology**

BSB: **083 004** Account: **49254 8311**

Reference: Enter child's Surname & Invoice number

_____

⌜ Credit card: (Fill in the details below and mail / fax to us)

Date: _____

Please charge my ⌜ Visa card ⌜ Mastercard ⌜ Other

Card #

Expiry Date: ___ ___ / ___ ___ Amount $ _____

Cardholders name _____

Cardholder's Signature _____

_____

After filling in your details please mail ***or*** fax to :

Spectrum Speech Pathology
P.O.Box 1016 Ashwood Vic 3147 **OR** Fax: **(03) 9813 8387**