Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
	☐ Other			
Cardholder Name (as shown on card):				
Card Number:			3 Digit Security Code:	
Expiration Date (mm/yy):				
Cardholder ZIP Code (from credit card billing address):				

I,________________________ , authorize ***Physical Therapy for Women, Inc*** to charge my credit card above for agreed upon copayments/coinsurances. I understand that my information will be saved to file for future transactions on my account and I can cancel this authorization at any time by contacting ***Physical Therapy for Women, Inc*** billing department at (910) 798-2318.

Customer Signature **Date**

_________________________ _________________________

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