Elkins Physical Therapy Service
Phone: 304-636-2340
Fax: 304-636-1583

Credit Card Payment Authorization

I ____________________________ authorize this credit card to be charged for copay, coinsurance,
(Card Holder's Name)
and/or deductible payments associated with your physical therapy services at the time they are rendered. You agree that these payments will continue to be charged to this credit card unless you inform us prior to the treatment date you wish to cease this agreement.

Billing Information

Billing Address ___________________________________ Phone # _________________________

City, State, Zip ___________________________________ Email ___________________________

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _______________________________________

Account/CC Number ______________________________________

Expiration Date ______ /______

CVV ______

Receipt ☐ Email ☐ Text

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify EPTS in writing of any changes in my account information or termination of this authorization at least 3 days prior to the next billing date. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions so long as the transactions correspond to the terms indicated in this authorization form.

CARD HOLDER'S SIGNATURE ___________________________________

DATE ___________________