



NAME: _____

DATE OF BIRTH: ____ / ____ / ____

TODAY'S DATE: ____ / ____ / ____

RECURRING PAYMENT AUTHORIZATION FORM

If you would like to enjoy the convenience of automatic recurring billing, simply complete the Credit Card Information section below and sign the form. All requested information is required. Upon approval, we will automatically bill your credit card for the amount indicated, and your total charges will appear on your monthly credit card statement. You may cancel this automatic billing authorization at any time by contacting us.

CUSTOMER & PAYMENT INFORMATION: *to be completed by customer*

Name: _____

Email Address: _____ Phone: _____

I authorize **Vitality Women's Physical Therapy** to automatically bill the card listed below as specified:
Product/Service description - Physical Therapy Treatment

Check all that apply:

COPAYS	OTHER PAYMENT TYPES
<input type="checkbox"/> \$ _____ Copay Frequency: <input checked="" type="checkbox"/> All copays charged as each PT session occurs	<input type="checkbox"/> Session Price Patient Balances Other _____ Frequency: <input type="checkbox"/> Charged as they occur <input type="checkbox"/> Charged on the _____ of every month <input type="checkbox"/> Other Frequency _____

Start Date: ____ / ____ / ____

End Date: End Date

☐ Other: _____

CREDIT CARD INFORMATION: *to be completed by customer*

Card Type: MasterCard VISA Discover AMEX Other _____

Cardholder Name: _____

Card Number: _____

Expires: ____ / ____

CVV/CVC: _____

Billing ZIP Code: _____

Customer Signature: _____ Date: _____

NOTE: You will be notified by email provided on this form when this credit card is charged.

FOR VITALITY USE ONLY: Date received: _____ Staff initials: _____