HEALING MOTION PHYSICAL THERAPY

Card on File Authorization Form

Information to be completed by cardholder:

The undersigned agrees and authorizes Healing Motion Physical Therapy, Inc. to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: Healing Motion Physical Therapy, Inc.

Patient's Name: _____

Name as it Appears on the Credit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits of Card: ☐☐☐☐

Expiration Date: _____

I, _____ authorize Healing Motion Physical Therapy to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to Healing Motion Physical Therapy, Inc.

_____ _____

Cardholder's Signature Date