WESTLAKE PHYSICAL THERAPY

CREDIT CARD ON FILE AUTHORIZATION

PLEASE PRINT CLEARLY

Date _____

Card Holder Name _____ Billing Zip Code _____

Type of Card: [ ] Visa [ ] MasterCard [ ] Discover

Last 4 Digits of Card Number _____ Expiration Date _____/_____
(please provide card to front desk)

Email Address for Electronic Statements/Receipts_____

I, _____, authorize Westlake Physical Therapy to charge the above credit card for payments owed to my account(s) for services rendered at their office. I agree to update any information regarding this account. The above information is correct and complete to the best of my knowledge.

Signature _____ Date _____

THANK YOU!

Your completion of this authorization form helps us to protect you, our valued patient, from credit card fraud.
All information entered on this form will be kept strictly confidential by Westlake Physical Therapy

OFFICE USE ONLY:

Patient Name _____

Account Name _____ Employee Initials _____ _____