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

# Recurring Credit Card Payment Authorization

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below each billing period. You agree that *no prior notification* will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I ________________________________ authorize Elkins Physical Therapy Service

(Card Holder's Name)

to charge my credit card indicated below for

$________________ between the 1st and 4th of each month.

(Amount $)

**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** ___________________