WYLIE PHYSICAL THERAPY

Recurring Payment Authorization

As part of a payment plan, you authorize regularly scheduled charges to your credit card or bank account. You will be charged the amount indicated below according to the schedule you select. A receipt for each payment will be provided to you via email.

I, _____ authorize **Wylie Physical Therapy** to charge my

credit card or bank account (*choose one*) ☐ Weekly ☐ Every Two Weeks ☐ Monthly

in the amount of $ _____ , beginning on the day this form is received by the office until my balance has been paid in full.

Patient Information:

Patient Name: _____ Date of Birth: _____

Cardholder/Account holder Name: _____

Email address for receipt: _____

Credit Card Information:

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Account/CC Number: _____ Expiration Date: _____

CVV: _____

Bank Account Information:

Routing Number: _____ Bank Account Number: _____

I understand that this authorization will remain in effect until I cancel it in writing. I certify that I am an authorized user of this credit card or of this bank account and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE: _____ Date: _____

(*Authorized User's Signature*)

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