Credit Card Authorization

By signing this form I hereby authorize Lilian Holm, PT, DPT to charge any unpaid account balances to my credit card listed below. I understand that I will not be billed, the card will be charged automatically, and that I can request a zero balance invoice at any time. I understand that by my signature below I am authorizing Lilian Holm to charge the credit card listed below for any and all unpaid balances on my account + a 3% service fee. This may include. but is not limited to, charges for treatment, fees for no-shows or late cancellations as defined by the cancellation policy available on www.lilianholm.com , and fees for checks that can not be processed due to insufficient funds. I understand that I am responsible for the payment of any charges for my physical therapy services that my health insurance policy does not cover and/or my health insurance company has not paid for.

I also understand that any inaccurately disputed chargebacks to this credit card will be assessed a $50 fee which will be added to my account and that my account may be turned over to a collection agency for further collections efforts on my delinquent accounts. I agree to update my credit card information if the credit card on file is no longer a valid form of payment.

☐ I would like to pay via Zelle or personal check, and agree to keep a valid CC on file.

Credit card type: Check one: Visa _____Mastercard____American Express____

Credit card number:_____

Credit card expiration date:_____

Verification/Security code (3-digit code on the back of the card):_____

Name as printed on credit card:_____

Billing address:_____

City:_____State:_____Zip code:_____

Your signature:_____

Printed name:_____

Today's date:_____