Lilian Holm Wellness
Physical therapy and Wellness coaching

Credit Card Authorization

This form authorizes Lilian Holm, PT, DPT to charge any unpaid account balances that are more than 30 days past due due my card listed below. 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 hereby authorize Lilian Holm to bill my credit card listed below for any and all unpaid balances on my account that are greater than 30 days past due.

☐ Check here to request that this credit card be charged for any self-pay visits.

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:____