FLORIDA OCCUPATIONAL Healthcare

Credit Card Authorization and Consent Form

I, _____ hereby authorize Florida Occupational Healthcare (FOHC) to keep my credit card information on file while I am attending physical therapy. FOHC is approved to charge my credit card for my patient responsibility on each visit I attend.

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: _____

Expiration Date: _____

Name of Cardholder:_____

Credit Card Billing Address: _____

_____

_____

Authorized Signature of Cardholder:_____

Date: _____

I would like a copy of the receipt emailed to me: ☐ Yes ☐ No

Email: _____

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