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: ___________________________________

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Authorized Signature of Cardholder:____________________________

Date: ______________________

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

Email: ____