A·H·Concierge
PHYSICAL THERAPY

Credit Card Authorization Form

Please review and enter all the details below. Your information will be processed through CardPointe, a secure & HIPAA compliant Virtual Payment Terminal. No charges will be made without your prior consent & approval.

I authorize AH Concierge Physical Therapy to charge my credit card that is attached for agreed upon services. I understand that my information will be saved to file for future transactions. No charges or transactions will be charged to my card unless I am notified and acknowledge each charge.

Cardholder Name (as shown on card): _____

Cardholder Date of Birth: _____

Cardholder street address (from credit card billing address): _____

Cardholders City, STATE, & ZIP Code (from credit card billing address): _____

Email (for receipts): _____

Phone #: _____

Card Type: □ VISA □ MAST □ DSCV □ AMER EXP □ Other: _____

Credit Card Number: _____

Expiration Date (mm/yy): _____ Security Code/CVC Code (from back of the card): _____

Patient/Guardian Signature (Sign or Type Signature here please): _____

Date of Signature: _____

Please review in full. If you have any questions, please contact us at (410) 934-4028. We appreciate your referrals! Thank you!

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