Credit Card Authorization Form

Please complete all fields.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other ___________________________________
Cardholder Name (as shown on card): _____________________________________
Card Number: ___________________________________
Expiration Date (mm/yy): ___________________________________
Cardholder ZIP Code (from credit card billing address): ____________________________________

I,________________________, authorize Artistic Athletic Physical Therapy and Performance, LLC to charge my credit card above ________________ for each day that services are provided. I understand that my information will be saved to file for future transactions during the length of treatment until formal discharge.

Customer Signature Date

** This authorization will remain in effect until cancelled. You may cancel this authorization at any time by contacting:

Dr. Talia Trapuzzano Eubanks, PT, DPT, SCS, ATC
apttalia@gmail.com
412-303-9957