Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until canceled.

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 Advanced Pediatric Therapies to charge my credit card above for agreed upon services and purchases. I understand that my information will be saved to file for future transactions on my account.

Please run card: Weekly⬜ Monthly ⬜, Monthly max:$_____ Run card monthly on this date: ___

Customer Signature _____ Date _____