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 cancelled.

Credit Card Information
Cardholder Name (as shown on card):
Card Type (circle one). VISA MASTERCARD DISCOVER AMEX
Card Number: CVV:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):

Aim Medical Services, LLC

I, _____ authorize Looking Ahead Pediatric Physical Therapy to charge my credit card for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Signature:_____ Date:_____

_____ _____

Patient's Printed Name Relationship to patient

_____ _____

Parent/Legal Guardian Printed Name Relationship to patient