Welsh Therapy and Associates

199 N. Broad Street, Doylestown PA, 18901

215-317-3329

**CREDIT CARD AUTHORIZATION FORM - PLEASE PRINT CLEARLY**

Name on Card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST, FIRST, MIDDLE

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET, CITY, STATE, ZIP

I hereby authorize Welsh Therapy and Associates (Horizon Wellness) to charge my credit card for any outstanding balance not paid within one week after \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient name)’s appointment.

Card Type: □ MasterCard □ Visa □ Discover □ American Express

Credit Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verification Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (last three digits on signature panel for most cards; four digits on front of AMEX card)

Billing Address: □ Same as above □ Different from above Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET, CITY, STATE, ZIP

Phone Number Associated with Account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_