



restore  
your core  
specialized physical therapy

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## **CREDIT CARD ON FILE AGREEMENT**

**PATIENT'S NAME:** \_\_\_\_\_

**CARDHOLDER INFORMATION:**

Name on Credit Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_

**Credit Card Type:**

**Please Circle:**                      AMEX                      VISA                      MASTERCARD

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

Exp Date: \_\_\_\_\_                      Security ID: \_\_\_\_\_

**Cardholder Signature:** \_\_\_\_\_ **Date:**

\_\_\_\_\_

I agree to keep my credit card information on file with Restore Your Core Physical Therapy LLC ("RYC PT") for unpaid balances, returned checks, or missed appointments (that have not been cancelled greater than 24 hours in advance per company policy).