Divine
Therapy & Wellness, LLC.
Striving for Excellence in Rehabilitation Care

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Credit Card Signature on File Form

In order to simplify the satisfaction of your co-payment responsibilities, **DIVINE THERAPY & WELNESS LLC**. enables you to make your payments by credit card. To facilitate processing and permit you to authorize payments via phone, **DIVINE THERAPY & WELNESS LLC.** requests that you sign below so that we can maintain your signature on file.

Please note that at no time will payments be processed without your awareness and prior consent.

I, the undersigned acknowledge that **DIVINE THERAPY & WELNESS LLC.** is hereby authorized to charge my credit card for payments authorized by me without obtaining any additional signatures.

Patient signature: ____

Date: ____

Credit Card: ____AMEX ____MASTERCARD ____VISA

Credit card number: ________________________ Expiration: _________