

****Permission to Store Credit Card Information:****

I, [Patient Name], hereby authorize [Clinic Name] to securely store my credit card information for the purpose of processing payments related to my physical therapy treatments.

****Terms and Conditions:****

1. [Clinic Name] will take all necessary precautions to ensure the security and confidentiality of my credit card information and to comply with the Payment Card Industry Data Security Standard (PCI DSS).
2. The stored credit card information will only be used for billing and payment purposes related to my physical therapy treatments at [Clinic Name].
3. I understand that I have the right to revoke this authorization at any time by providing written notice to [Clinic Name].
4. [Clinic Name] will not share my credit card information with any third parties, except as required by law.
5. I acknowledge that I am responsible for promptly updating my credit card information with [Clinic Name] in case of any changes or updates.

****Authorization:****

I authorize [Clinic Name] to store my credit card information as described above.

Patient's Signature: _____ Date: _____