

# Credit Card Pre-authorization

Please complete all fields. You may cancel this authorization at any time by contacting us.  
This authorization will remain in effect until cancelled.

**Card Type:**  MasterCard  VISA  Discover  AMEX  Other \_\_\_\_\_

**Cardholder Name (as shown on card):** \_\_\_\_\_

**Card Number:** \_\_\_\_\_ **V-code:** \_\_\_\_\_

**Expiration Date (mm/yy):** \_\_\_\_\_ **Cardholder ZIP Code (from credit card billing address):** \_\_\_\_\_

I authorize Process Therapy Institute to charge my credit card above for agreed upon purchases.  
I understand that my information will be saved to file for future transactions on my account.

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**Customer Signature**

**Date**

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**Name of Treatment Provider**

**Mailbox number**