Credit Card Payment Authorization – Customer Initiated

The below listed Merchant's card payment software allows for the secure storage of credit card information, through tokenization, for future payments associated with Merchant's health care practice. You authorize charges to your credit card by Merchant as payment for all products, services, fees and charges under your account with Merchant. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. Should Merchant or Cardholder change the terms of this agreement, including the use of the stored card data or its tokenization practices, below are the contact points.

Merchant Information

Address 27500 102nd Ave NW, Ste 1, Stanwood, WA 98292
Phone # (360) 629-7528
Email billing@northsoundpt.com

Customer Billing and Contact Information

Billing Address 27500 102nd Ave NW, Ste 1, Stanwood, WA 98292
Phone # (360) 629-7528
Email billing@northsoundpt.com

Card Details

◯ Visa ◯ MasterCard ◯ Discover ◯ American Express

Cardholder Name: _____
Card Number Ending in: ____/____/____/____/ (**Last 4 digits only)**
(Full card data, expiration date, and CVV will be captured on initial transaction and retained for future use)

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Merchant in writing of any changes in my account information or termination of this authorization. I acknowledge that the origination of credit card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card.

SIGNATURE _____ Date _____
(Cardholder Signature)

Print, complete and sign form. Give one copy to patient/guarantor/cardholder for their files, and save one copy to WebPT -- eDocs. Must be completed for EACH patient - do not save to multiple patient accounts (family members).