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t • 905 930 7876 f • 905 930 8886 e • frontdesk@absoluterw.com

Credit Card on File Authorization Form

Please complete this form allowing Absolute Rehabilitation and Wellness to keep your credit card on file for future payments. You may elect to provide us with credit card information separately for each payment.

Information to be completed by the card holder:

Cardholder Name: _____

Card Number: _____

Card Type: Visa MasterCard

Expiration Date: _____

Security Code: _____ (3 digit code on back)

Billing Postal Code: _____

E-mail: _____

I, _____, authorize Absolute Rehabilitation and Wellness to debit my credit card with one time payments from time to time, for payment of all charges arising for **no show/late cancellation fees**, **insurance deductibles/co-payments** and **any outstanding balances that we have not received payment for over a one month time frame**. Payment for the full amount of the owing balance will be debited to my credit card on the first business day of each month.

This authority is to remain in effect until Absolute Rehabilitation and Wellness has received written notification from me of its change or termination. This notification must be received at least thirty (30) calendar days before the next debit is scheduled to the card provided.

Absolute Rehabilitation and Wellness may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 30 days prior written notice to me.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any charges that are not authorized in accordance to this agreement.

Thank you for your cooperation,

Team Absolute Rehabilitation and Wellness.