PT Billing Associates INC
125 Lewis Wharf
Boston, MA 02110
617-523-2788
Fax 617-523-3063

Credit Card Authorization Form

I _____ give PT Billing Associates permission to charge my

Credit card listed below on the 15th Day of every month for my previous months invoice.

I will be responsible for all charges applied to my card. This agreement will be valid until I contact PT

Billing Associates in writing to terminate this agreement.

Credit Card Type _____

Card Number _____

Exp. Date_____

V Code _____

Card Address_____

Signature_____

Date_____

Email you want receipt to be sent to_____