KOH EDUCATION

Registration Form

Module Title _____ Date _____

Name on Certificate _____

Phone _____ Email _____

Address _____

Discipline- Required _____ **License State**_____ **License #(s)** _____
(PT, PTA, OT, OTA, DO, DC, MD, AT, LMT)

CERTIFIED PROVIDER LISTING ON WEBSITE

Name _____ **Facility**_____

Address _____
(If different than above)

Phone _____ **Fax** _____

Email _____ **Website** _____

CREDIT CARD AUTHORIZATION FORM

I, _____ approve KOH Physical Therapy, Inc./KOHed to have my credit card information on file which entails the account number, CV Code, expiration date, and the billing zip code that is associated with the credit card.

Card Holder Name _____

Cards Accepted – Visa, MasterCard, Discover, AmEx

CC # _____

Security Code___ ___ ___

Expiration Date ___ ___ /___ ___

Billing Zip Code _____

I approve KOH Physical Therapy, Inc/KOHed to charge my credit card on file regarding any payments that I owe which consists and is not limited to the course(s) and any balances that I may have.

KOH Physical Therapy, Inc/KOHed will not disclose any of your credit card information to anyone.

I have read and understand the above Office Approval for Credit Card Transactions.

_____ _____
Authorized Signature (Patient or Legal Guardian) Date

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