



**Sari Ann Lewis, OTR/L, RCST®**  
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I authorize Sari Hands PLC to charge my credit card for the patient responsible, non-insurance covered charges (co-pay, co-insurance, deductible, etc.) incurred during my course of treatment.

I understand that this information will be held in the strictest of confidence and will be used for the sole purpose described above.

Credit Card Type  
(Visa, MasterCard)

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Credit Card Number

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Expiration Date/ CVV Code

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Street #/Zip Code

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Cardholder Name

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Signature

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Date

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