

ALLOY PHYSICAL CARE INSTITUTE LTD
DIVISION OF OCCUPATIONAL HEALTH

Consortium Payment Form

Company Name: _____

PAYMENT METHOD

Card # _____ Exp. Date: _____

Name on Card: _____ CVC: _____

- * Declined payment methods may be charged an additional fee.
- * 3% processing fee for all credit card payments
(Office does accept cash and money orders)

By signing below, I understand and agree to the terms and conditions of the Alloy Physical Care Institute Division of Occupational Health. I also understand that the card list above will be charged for fees as listed in the Consortium Agreement. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in the contract.

Signature: _____ Date: _____