Downtown Physical Therapy and Rehab
CREDIT CARD AUTHORIZATION FORM

Our office requires payment at the time of the visits, patients can bring payment on the day of the treatment or we can keep your credit card on file for payment of any co-payment, coinsurance, deductible, no show policy charge or charge that may not be covered by your health insurance. You will be notified of the charge prior to it being processed, unless you give permission for it to be charged at the end of every visit. This form will be kept confidential and only authorized staff has access to the information and is stored in our secure payment processing website.

PATIENT'S NAME:

____

NAME, AS IT APPEARS ON CREDIT CARD:

____

BILLING ADDRESS: ____

EMAIL ADDRESS:____

AMEX/DISC/MC/VISA CARD #

____

EXPIRATION DATE: ________/_________

VERIFICATION CODE (3 or 4 DIGITS) _________________

WOULD YOU LIKE YOUR CARD CHARGED AT THE END OF EACH VISIT FOR THE BALANCE?
YES_________ intial

I acknowledge and authorize Downtown Physical Therapy and Rehab LLC to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within thirty days after I receive a statement. I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

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Cardholder Signature **Date**