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CREDIT CARD AUTHORIZATION FORM

Patient Information			
First Name:	Last Name:	Today's Date:	
Credit Card Holder Information		Credit Card Information	
Name on Card		Visa Account#	
Billing Address		Master Card Account#	
City / State		American Express Account#	
Zip Code		Expiration Date:	
Relationship to Patient:		CVV Code:	
Work Phone:	Home Phone:		

Credit Card Authorization

Please note our office files your claims to your insurance carrier(s) as a courtesy to you. Your insurance coverage is a contract between you and your insurance carrier, thus your entire account balance, including those charges filed to your insurance company, remains your **responsibility**. Your credit card will be charged for insurance co-payments at the time of service, for any balance owed after review of your final insurance payments, and for any late cancellation or no show fees. **The automatic charge for each late cancellation or no show is \$50.** Any credit remaining on your account after all insurance payments have been made will be refunded to you. I further understand that this form will be attached to my permanent records and can be used for all future treatment. It will not be divulged to any person not engaged in the maintenance of said files.

I, _____ hereby authorize ActiveCare Physical Therapy, PC to charge my credit card .

Signature:

Date:

Printed Name: