ACTIVECARE
PHYSICAL THERAPY®

12 West 37th Street Suite
1202 New York, NY 10018
Phone: 212-777-4374
Fax: 212-901-6992
www.bestptnyc.com

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, reschedule or no show fees. **The automatic charge for each late cancellation, reschedule or no show is $75.** 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.

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

_____ (initial) I decline to provide my credit card information. I understand that I am fully responsible for all charges for services rendered and will pay for any balances due.

Signature:

Date:

Printed Name: