Stay Ready Physical Therapy
5478 Wilshire Blvd Ste #208
Los Angeles, CA 90036
P: 323-936-7525
F: 323-936-7572

www.stayreadypt.com

CREDIT CARD AUTHORIZATION FORM

Patient Information		
Date	**First Name**	**Last Name**

Credit Card Holder Information	**Credit Card Information**
Name on Card:	**Card Type (Circle one):** **Visa Mastercard Discover Amex**
Billing Address:	**Card Number:**
City/State/Zip Code:	**Expiration Date:**
Relationship to Patient:	**CVV Code:**
Phone Number:	**Email Address for Receipts:**

Frequency		
Daily	**Weekly**	**Monthly**
☐	☐	☐

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 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 $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.

Please check with billing office for your detailed benefits.

I, _____ hereby authorize Stay Ready Physical Therapy to charge my credit card for any coinsurance, deductible or late cancel/no show charges that are applied to my account.

Signature:

Date: