ProActive Physical Therapy, LLC

"Be ProActive, Not ReActive"

AUTHORIZATION FORM

AUTHORIZATION:
Until further notice, I authorize ProActive Physical Therapy to charge the patient responsibility balance on my account to the following credit card:

CIRCLE ONE: Visa MasterCard Discover AMEX
Last Four Digits of Credit Card Number: _____
Exp. Date (mm/yy): _____

Per insurance contractual obligations, co-pays are due at the time of service. Per self pay agreement, self pay balances are due at the time of service. If I do not pay my co-pay or self pay balance at the office at the time of my appointment, I understand my credit card will be charged immediately. No statement will be sent for co-pays or self pay balances.

I understand that once the health plan has paid their portion for my care I will receive an Explanation of Benefits (EOB) from them. The health plan EOB will state any remaining balance to be paid by me. ProActive Physical Therapy will email a statement to the email address below with my balance due. I understand that I have 30 days to pay the statement or to communicate with ProActive Physical Therapy any discrepancies or to set up a payment plan. I understand that my statement may include No Show Fees, needling fees or other supplies fees not paid at the time of service or by my insurance.

If no payment is received or arrangements made, ProActive Physical Therapy with automatically charge the card on file after 30 days for the statement balance.

Please print email address: _____
_____ I prefer the statement be mailed via USPS.

Signature: _____ Date: _____

Printed Name: _____

NOTE: When your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization. Our system is registered with Visa and MasterCard and independently certified as a PCI-DSS Level One Service Provider.