Sports Motion Physical Therapy

Enhances Motion & Prevents Injury

AUTHORIZATION FOR PAYMENT

I HEREBY AUTHORIZE SPORTS MOTION PHYSICAL THERAPY TO CHARGE THE CREDIT CARD OR DEBIT CARD ACCOUNT LISTED BELOW FOR THE BALANCE OF MY DEDUCTIBLES, CO-PAYS, AND/OR CO-INSURANCES, AS WELL AS ANY PAYMENTS NOT MADE BY MY INSURANCE COMPANY. I UNDERSTAND THAT THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM MY DATE OF SERVICE.

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(SIGNATURE OF INSURED, AUTHORIZED, GUARANTOR) **(DATE)**

PATIENT NAME:		
CARDHOLDER NAME:		
BILLING ADDRESS:		
CITY: STATE: ZIP CODE:		
CREDIT CARD TYPE (CIRCLE ONE): VISA MASTERCARD		
CARD #:	EXPIRATION DATE:	SECURITY CODE: