CREDIT CARD BILLING AUTHORIZATION

Patient Credit Card on File Agreement

Patient Name: _____ **Case IE Date :** _____ / _____ / _____

Card Holder's Name (as shown on card): _____

Credit Card #: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ **Exp.** ____ / ____

Billing Address: _____

In the event a balance due is left unpaid at the time physical therapy services are provided, FitLife has implemented a secure and convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. We recommend you verify your own insurance before treatment begins. This form authorizes FitLife to charge your credit card on file for the unpaid amount due. (Acceptable forms of payment at the time of service include cash, check, VISA, Mastercard, Discover, or Amex credit cards.)

- I would like my card charged each date of service ☐
- I will present payment each date of service and understand if I do not present payment, my card will be charged ☐

- **Patients with Insurance:** Applicable co-pays, co-insurances, deductibles, claims unpaid due to lack of referral, balances if your plan is capitated, and/or No Show/Cancellation fees as per company policy are your responsibility. By providing your credit card information, you are giving FitLife permission to charge your credit card on file for processed insurance balances for which you are liable.
  - *Co-pays:* Co-pays are due at the time service is provided in our office. By providing your credit card information, you are giving FitLife permission to charge your credit card on file for your co-pay at the time of your visit if the co-pay is not paid with another acceptable form of payment that day.

- **Self-Pay Patients**: Self-pay patients are required to pay $100.00 for their initial evaluation, and $80.00 per visit thereafter, due at the time the service is provided in our office. By providing your credit card information, you are giving FitLife permission to charge your credit card on file for your self-pay fees at the time of your visit.

- **Outstanding Balance:** If your insurance provider has paid their portion of your bill (or the patient's bill listed on this form) and there is an outstanding balance owed, FitLife will notify you by sending a billing statement. If by the final notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card.

- **Multiple Users:** This card will only be authorized for the use of the credit card holder, his/her minor(s), or any patient(s) listed below. (Please print.)
  Patient Name**:** _____ Patient Name**:** _____

- For all scenarios, if the credit card transaction is declined, a $15.00 decline fee will be assessed.

I, _____ , authorize FitLife to capture my credit card information and securely store my credit card on file. I have read the above and understand my credit card will be charged for any charges, which are the patient's responsibility determined by their insurance. By signing this you authorize this agreement will remain in full effect until the expiration of the credit card account, at which time you may submit changes to your credit card information to the Physical Therapy desk.

_____	_____	_____
Card Holder Signature	**Print Name**	**Date**