Credit Card Authorization Form

I authorize Good Health Physical Therapy to automatically charge my credit card for any outstanding balance on my account after claims are submitted and processed by my insurance, beginning from the date signed below. Balances may include:

- Co-pays
- Deductibles
- Supplies Purchased
- Any unpaid balance

I agree to allow Good Health Physical Therapy to charge the personal credit card provided upon receipt of my insurance EOB or if there is an outstanding balance on my account or another client's account as designated below.

Patient Name ____

Cardholder Name ____

Credit Card Number ____

Expiration Date ____________________________ **CVV Code** _____________________________

Billing Zip Code associated with Credit Card ____

Cardholder Signature ____ **Date** _______________