GOOD HEALTH
PHYSICAL THERAPY & WELLNESS

Electronic Billing Authorization Form

Please email my billing statements to the email address on file: ◯ YES ◯ NO
If NO, statements will be mailed to the mailing address on file.

Authorize automatic credit card charges for any unpaid balances: ◯ YES ◯ NO
If YES, please fill out the following Credit Card Authorization Form.

Allow mass emails for marketing purposes: ◯ YES ◯ NO
(i.e. clinic exercise classes, details about owner's new book coming out, etc. If NO, you will still receive emails regarding pertinent clinic information such as inclement weather closures.)

Credit Card Authorization Form

I authorize Good Health Physical Therapy to 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** _____