Print Name: ___________________________________

Individual's Financial Responsibility

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

Individual's Signature ____ Date ____________________

Credit Card Payment Authorization

I authorize regularly scheduled charges to my credit card. I will be charged the amount indicated below each billing period. A receipt for each payment, less insurance, will be provided to you and the charge will appear on your credit card account statement. I agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I ________________(initial) authorize Primus Physical Therapy to charge my credit card below for up to

$__________________ beginning on ________________ (Date) every physical therapy session attended

and $50 for every cancellation with less than 24 hour notice.

Billing Details

Billing Address ____ Phone # ________________________

City, State, Zip ____________________________ Email ______________________________________

Credit Card Information

❑ - Visa; ❑ - MasterCard; ❑ - AMEX; ❑ - Discover

Cardholder's Name - ____

Credit Card Number - _________ - _________ - _________ - _________

Expiration Date - _______ / _______

Security Code (CVV) - _________

Individual's Signature ____ Date ____________________