CLEARWATER
PHYSICAL THERAPY

Credit Card Authorization Form

Patient Information

Patient Name: _____ Date of Birth: _____

I _____ hereby authorize Clearwater Physical Therapy to charge my credit card for medical services rendered or for outstanding balances, subject to the terms below. I understand that I am agreeing to one of the following three options:

☐ **Option 1: Pay once a month**
I would like to receive a statement via text or email for services rendered and understand my card will be charged for any outstanding balances on the _____ of each month.

___ Text ____ Email

☐ **Option 2: Pay at time of service**
I would like Clearwater Physical Therapy to automatically charge my credit card for services rendered at the time of service and for any outstanding balances after services are completed.

☐ **Option 3:** Payment plans are available upon request.

Credit Card Information

- **Card Type**: [Visa / MasterCard / AmEx / Discover / Other]
- **Card Number**: _____
- **Expiration Date**:_____
- **CVV Code**: _____
- **Billing Address**: _____

Patient's Signature

By signing below, I authorize the above terms and choose the payment option indicated (Monthly Charge or Automatic Charge). I confirm that the information provided is accurate and I understand the terms of this authorization.

Signature of Patient: _____ **Date:**_____

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Date: