KIMA | CENTER FOR PHYSIOTHERAPY & WELLNESS

(rev. 12/2013)

2014 Credit Card Authorization Form

Client Name: ____
Name as it Appears
on the Credit Card: ____

I authorize that the unpaid balance be charged to my major credit card, as listed:

Payment Method:
☐ Visa ☐ MasterCard ☐ American Express

Account Number: ____

Expiration Date: ______ / _________ (MM/YYYY)

V-code: ____________ (3, 4 or 7 digit security code)

Credit Card Billing Address:

Street: ____

City: _________________________________ State: ___________ Zip: _______________

Cardholder's Name: ____

Cardholder's Signature: ________________________________ **Date**: ________________

Authorization to Keep Credit Card Number on File (check box below):

The use of keeping your credit card on file is for your convenience. You may elect to provide us with payment information with each visit if you do not wish us to keep your credit card on file

☐ **By checking this box**, I agree to:

1. Authorize KIMA Physical Therapy PLLC to process the above credit card as "Signature on File" for all services rendered and charges incurred. I understand this authorization will expire upon conclusion of care;
2. Keep this credit card on file with KIMA Physical Therapy PLLC;
3. Bill all charges to the above credit card;
4. Provide KIMA Physical Therapy PLLC with written cancellation if, during the course of treatment, I decide to elect out of keeping my credit card on file. Otherwise, I understand that this authorization will expire upon conclusion of care; and
5. Authorize KIMA Physical Therapy PLLC to charge the credit card indicated above for any account balance which includes, but not limited to, payment for services, supplies, co-insurance, fees for late cancel and no show appointments, copying fees, etc.

Cardholder's Signature: ________________________________ **Date:** ________________

A COPY OF BOTH SIDES OF THE SIGNED CREDIT CARD MUST BE SUBMITTED WITH THIS FORM.

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