ALIGNMEND
PHYSICAL THERAPY

Credit Card on File Billing Authorization Form

AlignMend Physical Therapy is offering a secure and convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed to and processed by your insurance carrier, and the insurance portion of the claim has posted to your account, or in the event that valid insurance information was not provided at the time of service.

I, _____, authorize AlignMend Physical Therapy to capture my credit card information and securely store my credit card on file.

I authorize AlignMend to charge my credit card on file for any balance owing in my account that has been outstanding for 30 days.

I agree AlignMend Physical Therapy may charge my credit card on file for the balance due if the balance has been outstanding for more than 30 days. This authorization relates to all balances not covered by my insurance company for services provided by AlignMend Physical Therapy. This could be amounts resulting from balances related to copayment, deductible, co-insurance, non-covered services, or denials for no coverage/eligibility but is not limited to these scenarios. Please note, you will receive monthly bills regarding outstanding balances not covered by your insurance company. AlignMend Physical Therapy will not run you card without contacting you for up to three attempts. If three attempts of contact have been made, the card on file will be processed for the total amount of the outstanding balance.

I understand that this form is valid until I give a 30-day written notice to cancel and authorization to AlignMend Physical Therapy. Written notice must be submitted to AlignMend Physical Therapy, 2208 NW Market St. #307, Seattle, Washington 98107 or Paige@AlignMendPhysicalTherapy.com

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Patient Name: _____

Account#: _____

Card Holder's Name (as shown on card): _____

□ Visa □ Master Card □ Discover □ American Express

Credit Card Number: _____

Expiration date (mm/yy): _____ / _____

CVC: _____

Email: _____

_____ _____

Cardholder Signature Date