AUTOMATIC PAYMENT AUTHORIZATION

Patient Name: ____________________________ Today's Date:__________________

I have elected to sign up for automatic payment of my account balance using either a credit card or bank account. I authorize TEAM Physical Therapy, P.C to debit the account I have provided below for the listed amount on the listed date of each month until my account has been paid in full. I understand that this authorization only applies to this current case and that I must sign up for this service for each future course of treatment I may need. I understand that TEAM Physical Therapy, P.C. will maintain strict security of my financial information and not share this information with any individual, company or business.

Credit Card Type: ______________________ (Visa, Master Card, Discover, Care Credit)
Name on Front of Card: ____
Billing Address for Card: ____
Credit Card Number stored electronically on Navicure's secure website.

Or

Name of Bank:____
Name on Account: ____
Address of Account Holder: ____
Bank Routing and Account Number stored electronically on Navicure's secure website.

Amount to be Processed Each Month: ______________________

Date each month I want my account debited: ________________

___ I would like a receipt of this transaction: emailed to ___________________________

___ I would like a receipt of this transaction mailed to the following address:

____

___ I do NOT want a receipt.

Payer Signature: _________________________________ Date: ___________________

Payer Printed Name: _____________________________