NEW CLIENT REGISTRATION FORM
Complete this form and fax to: (904)223-2365
Or scan and email to: jaxpt@fyzical.com

FYZICAL®
Therapy & Balance Centers

Phone: (904) 223-2363 Web: FYZICALcom/Jacksonville

Patient Name: _____ DOB: _____

Credit Card Authorization Form

The purpose of this form is to authorize In Motion Physical Therapy LLC to retain a valid credit card on file for you as our patient. This form will be kept confidential.

Initial below to authorize In Motion Physical Therapy LLC to keep my signature on file and charge my credit card for the following reasons.

_____ **Co-Pay, Co-Insurance, & Deductible** In Motion Physical Therapy LLC will charge the credit card listed below $60/month until the balance is paid off.

_____ **Self Pay Services** Including Massage, Physical Therapy, and retail Items.

In Motion Physical Therapy LLC will automatically charge my credit card for the following reasons unless other explanation or form of payment is received.

1. **Outstanding Balances** If you, as the patient, have an outstanding balance greater than 90 days with the clinic, we will charge an agreed amount until the balance is paid off.
2. **No-Show Appointments** Miss a scheduled appointment without 24-hours notices to cancel or reschedule, In Motion Physical Therapy LLC reserves the right to charge the credit card listed below $25.00 for our standard no-show fee and a receipt will be sent to the current address on file. Excluding a written doctor's excuse, police report, etc. in the event of unavoidable emergencies.

Other than the conditions mentioned above, under NO circumstances will In Motion Physical Therapy LLC share your credit card information. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart.

Having read this form and talked with the staff, my signature below acknowledges that I give my authorization and consent providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X_____ **X_____**

Patient signature Date **Staff signature Date**

(or person authorized to sign for patient)

Name as it appears on Credit Card: _____

Visa/MC/AMEX/Discover Card Number: _____

Expiration Date: ____/____/_____ CVV: _____ Zip Code: _____

X_____

Signature as appears on credit card

Patient Signature: _____ Date: _____

Revised: 1/29/2018