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 applies for the calendar year, and I must notify the billing office to stop automatic payments.** 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)
Name on Front of Card: _____
Credit Card Number: _____
Security Code: _____ Expiration Date: _____ Zip Code: _____

Or

Name of Bank: _____
Name on Account: _____
Bank Routing Number: _____
Account Number: _____

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: _____