Credit Card Authorization

I hereby authorize Lilian Holm, PT, DPT to charge my card listed below with any and all charges for physical therapy that are my responsibility according to the determination of my insurance provider. By my signature below I am authorizing Lilian Holm to charge the credit card listed below for these charges, which may include deductibles, copays, co-insurance + a 3,3% processing fee. I also authorize Lilian Holm to charge any fees for late cancellations or no-shows as defined by the cancellation policy available on www.lilianholm.com , as well as and fees for checks that can't be processed due to insufficient funds. I understand that I am and agree to be responsible for the payment of any charges for my physical therapy services that my health insurance policy does not cover.

I also understand that any inaccurately disputed chargebacks to this credit card will be assessed a $50 fee which will be added to my account, and that my account may be turned over to a collection agency for further collections efforts on my delinquent accounts. I agree to update my credit card information if the credit card on file is no longer a valid form of payment.

If I have requested to be billed in order to use another form of payment, I hereby authorize Lilian Holm to bill my credit card listed below for any and all unpaid balances on my account within 30 days of the date of the invoice, which will be emailed to me.

☐ Check here to request that this credit card be charged for any self-pay visits.

Credit card type: Check one: Visa _____Mastercard____American Express____

Credit card number:_____

Credit card expiration date:_____

Verification/Security code (3-digit code on the back of the card):_____

Name as printed on credit card:_____

Billing address:_____

City:_____State:_____Zip code:_____

Your signature:_____

Printed name:_____Date:_____