

CREDIT CARD AUTHORIZATION FORM

I authorize The Desert Institute of Physical Therapy to charge my credit card for the patient responsible, non-insurance covered charges, to include **CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES ETC.**, that may be incurred during the course of my treatment.

I understand that this information will be held in the strictest of confidence and will be used for the sole purpose described above.

Credit Card Type (Visa, MasterCard, Amex)

Credit Card Number *Please indicate if this is a Debit Banking Card: Yes _____ No _____

Expiration Date

Cardholder Name

Signature

Date