INTOUCH & MOTION

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CREDIT CARD ON FILE POLICY

At InTouch & Motion we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Please be advised, InTouch & Motion requires 24 hour notice for any canceled or rescheduled non-emergency appointments. Any non-emergency cancellations or rescheduled appointments with less than 24 hours notice as well as no call/no shows will be subject to a cancellation fee of your full session fee of _____. These sessions are not billable to your insurer.

I (we) authorize InTouch & Motion to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Visa ☐ Mastercard ☐ Discover ☐ Other _____

Credit Card Number _____

Expiration Date _____ / _____ 3 Digit Code on Back _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request InTouch & Motion to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by InTouch & Motion, which may include the full therapy fee, my copay or coinsurance fee of _____, unmet deductible and other patient responsibility fees.

Furthermore, I authorize and request InTouch & Motion to charge my credit card the full therapy fee of _____, if I do not cancel or reschedule my appointment with 24 hour notice.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30 day notification to InTouch & Motion in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____