H2Orthopedic Credit Card Authorization Form

Patient Name: _____ Date of Birth: ____/____/_____

The purpose of this form is to authorize H2Orthopedic to retain a valid credit card on file for you as our patient. All patients are required to complete this form. This form will be kept confidential and only authorized staff will have access to this information.

I authorize H2Orthopedic Physical Therapy to keep my signature on file and charge my credit card for the following reasons:

1. H2Orthopedic reserves the right to charge the credit card listed below for all current patient balances, co-payments, co-insurances, deductibles and late cancellation fees. If patient balances exceed $50, H2Orthopedic will charge the credit card listed below $50/month until the balance is paid off or if other payment terms have been agreed upon. This notice serves as your consent to being charged for all current patient balances on your account.
2. If you, as the patient, miss a scheduled appointment without 24-hours notice to cancel or reschedule, H2Orthopedic has the right to charge the credit card listed below $50.00 for our standard late cancellation/no-show. A receipt will be available upon request. This notice serves as your consent to being charged for all no-show or late cancelled appointments.
3. If we receive notice that a payment is returned to us for any reason, H2Orthopedic has the right to charge the credit card listed below a $25.00 returned check fee as well as a $25.00 processing fee. This notice serves as your consent to being charged for all returned payments.

Other than the conditions mentioned above, under NO circumstances will H2Orthopedic share your credit card information for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

_____ ____ / ____ / ____ Patient Acknowledgement/Signature Date