ROGUE
PHYSICAL THERAPY

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time. This authorization will remain in effect until cancelled. Your card information will be held on file with my credit card processing company, Worldpay with whom I have a HIPPA Business Associate Agreement through WebPT. After scanned into your file this paper will be shredded. For more information about Worldpay security practices, please visit https://www.worldpay.com/en-gb/privacy-policy

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ HSA

Cardholder Name (as shown on card):

_____

Card Number:

_____

Expiration Date (mm/yy):

Three Digit Code (on back of card)

_____

Cardholder ZIP Code (from credit card billing address):

_____

I, _____, authorize **Nathan Lewis DPT LLC** to charge the card above for copays/therapy sessions /no show fees/etc., for services provided to

_____. I understand that my information will be saved in my file for future transactions on my account.

_____

Signature Date

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PATIENT INFORMATION & FINANCIALS

PATIENT INFORMATION

Name_____ Date of birth _____ Social security number_____

Address _____

CITY STATE ZIP

Home phone #_____ Cell phone #_____ Okay to leave a message? _____

Email _____ Preferred contact method _____

Whom to contact in case of an emergency _____ _____

NAME PHONE #

Responsible Party _____ Relationship to Patient _____

FINANCIAL INFORMATION

Name of person responsible for this patient_____Relationship_____

Address & Demographics if different than patient _____

ADDRESS CITY STATE ZIP

_____

DATE OF BIRTH CONTACT PHONE NUMBER EMAIL ADDRESS OKAY TO LEAVE A MSG?

If you have insurance, it is your responsibility to contact your insurance company to find out what portion of the fees will be covered by your plan. If you would like me to bill your insurance company for you, please provide the following information and a copy of your insurance card.

Name of Insurance Company _____Plan Type_____

Subscriber's Name _____Subscriber's D.O.B_____

Subscriber's I.D. #_____Group I.D. #_____

Has the yearly deductible been met? _____Co-pay Amount _____

Secondary Insurance Company _____Plan Type _____

Subscriber's Name _____Subscriber's D.O.B_____

Subscriber's I.D. #_____Group I.D. #_____