RX PHYSICAL THERAPY, PLC

FINANCIAL AGREEMENT & CREDIT CARD AUTHORIZATION

I hereby authorize RX Physical Therapy to keep my credit card information on file. This authorization allows RX Physical Therapy to charge my account for physical therapy-related balances, including, but not limited to, copays, deductibles, coinsurance, and any outstanding patient-responsible amounts.

Financial Agreement

I accept financial responsibility for all services rendered to me. I agree to pay any balances not covered by my insurance, including “non-covered” services. I understand that failure to pay may result in collections and/or automatic credit card charges.

Automatic Charges Policy

If my account balance remains unpaid for 30 days after invoicing, RX Physical Therapy may charge my credit card for the full balance. This charge can be avoided by making timely payments, which are my responsibility as the patient. Please note that an unpaid balance will begin accumulating 2% interest after 60 days of invoicing.

Cancellation and No-Show Policy

I agree to provide at least 24 hours’ notice for any appointment changes. I understand that I will be charged a $50 fee for missed appointments, cancellations with less than 24 hours’ notice, or arriving 15 minutes late or more.

Confidentiality and Payment Policy

My credit card information will be stored securely and used only under this agreement. This policy ensures timely payments, reduces outstanding balances, and supports uninterrupted care.

Patient Name: _____

Credit Card Number: _____

Expiration Date: _____ CVV: _____ HSA/FSA card: ☐

**a 3% processing fee will be added to all credit card payments* VISA ☐ ☐ DISCOVER ☐ ☐

☐ Billing address same as mailing address

Billing Address (if different):

_____

Patient/Guardian Signature **Date**

RX Staff Signature **Date**