Permission to Charge Stored Credit Card

I, the undersigned patient, authorize BrownStone Physical Therapy to charge my credit card for any patient responsibility, including but not limited to co-pays, deductibles, and any unpaid balances for physical therapy services rendered.

I understand and agree to the following:

1. I am responsible for payment of all charges incurred for the services provided by BrownStone Physical Therapy
2. I understand that I am required to pay my co-pay and deductible at the time of service unless other arrangements have been made.
3. Any unpaid balances after insurance claims have been processed will be charged to the credit card provided.
4. I will be notified of the amount to be charged before any payment is processed.
5. I will keep my credit card information up to date with the clinic and notify them of any changes in the card's status.
6. I have the right to dispute any charges, and BrownStone Physical Therapy will work with me to resolve any billing issues.

By signing below, I acknowledge that I have read and understood the terms outlined above, and I authorize BrownStone Physical Therapy to charge my credit card for any outstanding patient responsibility amounts.

Patient's Signature: _____ Date: _____
(Please sign and date above)

Credit Cardholder's Signature: _____ Date: _____
(Please sign and date above)