Back to Health PT
11824 Southwest Highway
Palos Heights, IL 60463

Back to Health PHYSICAL THERAPY

Pre-Authorized Use of Credit Card

I authorize the office of Back to Health PT, LLC to charge the credit card on file for payment of any coinsurance or deductible determined to be my responsibility upon processing of my claim by my insurance. I understand that I can choose to make payment via another method if I prefer (Flex Spending, other credit card or check), however we keep a copy of credit card information on file throughout duration of treatment.

I understand that this is my notification that I will be charged in full for any balance 30 days past the statement date.

I assign my insurance benefits to the provider listed above. I understand that this form is valid throughout the duration of course of care unless I cancel the authorization through written notice to the healthcare provider.

☐ I prefer to keep a copy of my credit card electronically stored in the secure system in place of storing it on paper. I agree to allow a $1 charge to be placed on the card to hold it on file. This will be reimbursed if insurance determines that I owe no out of pocket costs for my therapy services. (check box if choosing this option).

The specific credit card information listed below the dotted line will be shredded once your balance is paid in full

____
Patient Name

____
Cardholder Name - as it appears on card

____
Cardholder Address

____
City State Zip

____
Cardholder Signature Date

- -

____
Credit Card Account Number Expiration CVS