Credit Card Authorization Form

Patient Financial Responsibilities: DEDUCTIBLES, CO-PAYS, AND CO-INSURANCE'S ARE DUE IN FULL AT THE TIME OF SERVICE. At the beginning of treatment, we require you secure your account with a credit card. We offer two options for charging the patient responsibility relating to your treatment. As a courtesy to you, we can automatically charge your card the estimated patient responsibility for each visit based on the quoted benefits from your insurance company throughout your treatment. Once your claims have been processed, the Explanation of Benefits from your insurance company will determine the patient responsibility and any necessary changes to the amount due will be made. Additionally, we will use the credit card to process any cancellation or no-show fees that you have incurred. There will be a no-show fee of $25 for same day cancellations. A receipt will be provided for any charges processed by A Good Life Massage, LLC, at your request. If you prefer to bring in payment at every appointment, we will only use your credit card to charge any remaining fees at the end of your treatment, once all claims have been processed by your insurance company.

(Debit cards can be used if they have a major credit card logo.)
Credit Card: □ Visa □ MasterCard □ Discover
Patient's Name: _____
Name on Card: _____ Acct #:
_____ Expiration: ___/___/_____ Security Code:
_____

Billing Address:
_____ ____
City, State, ZIP Code:
_____ Do you require an itemized/HSA receipt? _____ Amount to be charged:
_____ Please initial the option you prefer:

_____ I will pay the estimated amount due per session at each appointment and will have my credit card on file available only for any remaining balance I owe once my treatment has ended.

_____ I agree to allow Rehab United to charge my credit card on file for the amount due at each appointment and for any remaining balance I owe once my treatment has ended.

I have read this Financial Policy and I agree to the terms and conditions outlined within this policy. I hereby consent to massage care and treatment as deemed necessary and proper by the staff of A Good Life Massage, LLC. Furthermore, I agree to assign all health insurance benefits directly to A Good Life Massage, LLC and understand that I am responsible for any costs not covered by my health insurance.

Patient/Responsible Party Signature: _____ Date:_____ _____