



Credit Card Authorization Form

I, _____ (print name), authorize Agility Physical Therapy and Sports Medicine, to charge the card I gave to be on file, for agreed upon purchases.

No shows, late cancellations, or any Cryoskin© products, cannot be charged to any Health Savings Account cards.

You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.
We require all cards to be on file for the remainder of your care.

(initials) I understand that my information will be saved to file for future transactions on my account. Failure to pay a bill within 15 days of a statement will result in an automatic charge to the card on file. As a small practice, we can no longer accept other forms of payment due to a high volume of lack of payment in the past. We require every patient to have a card on file through our very secure network to ensure that we have payment in a timely manner. If you absolutely do not wish for your card to be on file, or prefer to pay by check, then the package that you have selected will need to be paid 100% up front to ensure we have full payment for services rendered.

Client Signature

Date