



Physical Therapy for Pelvic Pain, Incontinence, Infertility and Gastrointestinal Disorders

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CREDIT CARD AUTHORIZATION

I authorize Kirk Center for Healthy Living, PC, to bill the following credit card for services, missed appointments, deductibles, co-insurance or co-pays that have not been paid by my insurance carrier. I understand Kirk Center for Healthy Living, PC, will bill my insurance company and that my credit card may be charged after insurance payment is received. I understand that if my credit card is declined, a \$50.00 fee will be posted to my account. If I fail to respond to monthly statements, collection action may be taken:

Name of Patient

This authorization is to remain in effect until I cancel it in writing.

The payments I am authorizing are:

- Account delinquency of 75 days
- Monthly balance billing

For your convenience we accept cash, personal checks, **Visa**, **MasterCard** and **Discover**.

Card Type	Card Number	Expiration Date	CVV Code
Visa			
MasterCard			
Discover			

Name as it appears on the card: _____

Authorized Patient/Guardian/Cardholder's Signature: _____

Billing address on file with credit card:

Street Address: _____

City / State / Zip: _____

Date: _____