Kirk Integrative Physical Therapy

16618 W 159th St, Suite 401 & 402, Lockport, IL 60441
Phone: **(815) 838-0529** ❖ Fax: **(815) 838-0652**
Website: **kc4hl.com**

CREDIT CARD AUTHORIZATION

I authorize Kirk Integrative Physical Therapy, PC, to bill the following credit card for services or missed appointments. I understand that if my credit card is declined, a $50.00 fee will be posted to my account.

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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

☐ Missed appointment charges

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: ____________________