C.O.R.E.
PHYSICAL THERAPY
Center for Orthopedic Rehab and Exercise

TERMS OF PAYMENT AGREEMENT

I, _____ acknowledge and accept full and complete responsibility for prompt payment of all services by C.O.R.E. Physical Therapy, PLLC. I acknowledge that prompt payment is due at the time of services rendered.

I understand that health insurance policies and reimbursement are between myself and the health insurance company, that all services rendered are charged directly to me, and that I am personally responsible for payments to C.O.R.E. Physical Therapy, PLLC. I understand that agreements regarding fee schedule and charges for canceled appointments are between myself and C.O.R.E Physical Therapy and are not related to potential health insurance coverage.

_____

Signature Date

AUTOMATIC BILLING AUTHORIZATION FORM

For your convenience, if you would prefer us to automatically bill your credit card, please sign below. Our electronic medical records (EMR) software safely stores and encrypts your information in the system.

Sign Here: _____

From Credit Card

I authorize you to charge my bill directly to the credit card listed below.

_____ _____

Name on credit card Card Number

_____ _____

Expiration Date Verification Code