CREDIT CARD AUTHORIZATION

I, authorize Kinetic PT (171 Lake Street, Ramsey, NJ or 182 Kinderkamack Road, Park Ridge, NJ) to automatically bill my credit card for my visits.

Card Number: ______________________________ Exp: ______________________

Card Holders Name: ____

Billing Address: ____

I understand that I am responsible for all charges and fees associated for transactions unable to be processed by Kinetic PT or by my financial institution.

In addition, I agree to alert Kinetic PT of any necessary changes regarding my credit card information.

Client Signature: ______________________________ Date: ______________________

(IF CARD HOLDERS NAME IS DIFFERENT THAN PATIENT'S NAME, PLEASE HAVE CARD HOLDER SIGN BELOW TO AUTHORIZE THE USE OF THEIR CARD BY THE CLIENT)

I, ______________________ (card holders name), authorize Kinetic PT to bill my credit

card above relating to, ____________________ (patients name).

********PLEASE GIVE FRONT DESK CREDIT CARD TO MAKE A COPY (FRONT/BACK) OR ATTACH COPY OF CREDIT CARD (FRONT/BACK) ********