Helen M. Sarandrea P.T., PLLC
Physical Therapy & Sports Care

# CREDIT CARD ACCEPTANCE

**NOTICE TO PATIENT/GUARDIAN**

You are entitled to an exact copy of any agreement you sign. You have the right at any time to pay the unpaid balance due under penalty without penalty. You have a right at this time to receive an itemization of the amount financed. **Any care not paid for by your existing insurance coverage will require payment IN FULL (co-payments, coinsurance, deductibles etc.) at the time of the provided service or upon notice of insurance claim denial.**

☐ I want an itemization ☐ I do NOT want an itemization

I have read, understood, and agreed to the above financial agreement, terms and conditions, and schedule of payments.

_____ _____
Signature of responsible party Date

_____ _____
Doctor's signature Date

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize to release all information necessary to secure the payment.

_____ _____
Signature Date

Please charge my: ☐ VISA ☐ Mastercard ☐ American Express ☐ Discover

Card Number: _____ Exp. Date: _____

Security Code: _____ Authorized Signature: _____

Print Name: _____ Address: _____

City: _____ State: _____ ZIP: _____

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