MRPT
MARIANNE RYAN
PHYSICAL THERAPY

CREDIT CARD ON FILE AGREEMENT

PATIENT'S NAME: _____

CARDHOLDER INFORMATION:

Name on Credit Card: _____

Billing Address: _____

_____

Credit Card Type:

Please Circle: AMEX VISA MASTERCARD

Credit Card Number: _____

Exp Date: _____ Security ID: _____

Cardholder Signature: _____ Date: _____

I agree to keep my credit card information on file with MRPT Physical Therapy LLC for outstanding co payments, unpaid balances or checks issued to me by my insurance company for treatment or services rendered while I was a patient at MRPT Physical Therapy LLC.

You will receive prior notification from us before any charges are made to your credit card.