



It's Time to RISE.

Credit/Debit Card Authorization Form

I, _____ authorize Rise Pacific Physical Therapy and Sports Medicine to charge my credit/debit card for the following:

- Copay or coinsurance rate for all attended appointments
- \$20.00 for any appointment missed or canceled with less than 24 hours' notice
- Any portion of billable services not covered by my insurance policy

- Visa
- Mastercard
- American Express
- Discover

Name Printed on Card: _____

Card Number: _____ Expiration Date: _____

CVC Number: _____ Billing Address Zip Code: _____

By signing below, I certify that the above information is true and accurate and that I am an authorized user on the credit card/debit account above. I authorize Rise Pacific Physical Therapy and Sports Medicine to keep my credit/debit card information on file and charge the above fees automatically and on an ongoing basis until or unless I cancel these automatic payments in writing. I understand that I am responsible for notifying Rise Pacific Physical Therapy and Sports Medicine if my credit/debit card information needs to be updated. Rise Pacific Physical Therapy and Sports Medicine agrees to ONLY charge for services rendered or for appointments not cancelled 24 hours in advance (at administrators' discretion), and will provide notice of charges. I understand that if I wish to cancel an appointment, I will need to speak with an employee of Rise Pacific Physical Therapy and Sports Medicine or leave a recorded voicemail message at (818) 318-2430.

Signature: _____ Date: _____