CONFIDENTIAL
VIP Express Checkout Authorization

Patient Name: _____

Cardholder Name: _____

Card Type: (please circle) Debit Card Visa Card Mastercard

Card Number: _____ Exp. Date: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Vail Sports Medicine Physical Therapy, P.C.

PO Box 1311, Vail, CO 81658
(970) 476-7510

is authorized to keep my signature on file and to issue a credit memo to my credit card and/or debit card account for any overpayment for services. Credits in excess of $300.00 will be pre-authorized by phone.

_____ Cardholder initials

is authorized to keep my signature on file and to issue a charge memo to my credit card and/or debit card account for any outstanding balance for services. Charges in excess of $300.00 will be pre-authorized by phone.

_____ Cardholder initials

GUARANTEE OF PAYMENT

I hereby guarantee payment of physical therapy expenses for the above-mentioned patient while at Vail Sports Medicine Physical Therapy. I understand that payment is required at the time of service unless other arrangements have been agreed upon.

I understand that I am financially responsible to Vail Sports Medicine Physical Therapy for all charges incurred, including those not covered or paid for by my insurance carrier. I also understand that I am financially responsible to Vail Sports Medicine Physical Therapy if a problem develops with my insurance carrier and payment is not made within 30 days.

Should this account become delinquent, I understand that I will be responsible for any and all collection/attorney/filing fees.

Date: _____ *Authorized:* _____

Responsible Party

Date: _____ *Authorized:* _____

Billing Manager