

**Excel Physical Therapy & Sports Medicine Clinic
Patient Care Payment Agreement**

I AGREE TO THE FOLLOWING:

For Charges billed to insurance

1. Excel Physical Therapy & Sports Medicine may charge the credit card below for services not reimbursed by my insurance company after 60 days after notifying me of the outstanding balance.
2. Excel Physical Therapy & Sports Medicine will collect my outstanding balances including co-pays, co-insurance, deductibles and non-covered services on the credit card below.
3. Excel Physical Therapy & Sports Medicine will refund any overpayment to the credit card below.
4. If I receive direct reimbursement from my insurance company for services not paid to Excel Physical Therapy & Sports Medicine, I will endorse that check and submit it to Excel Physical Therapy & Sports Medicine within 5 business days. Otherwise, I authorize Excel Physical Therapy and Sports Medicine to collect the full amount of my balance on the credit card below.

For Charges not billed to insurance

1. If I cancel an appointment with less than 24 hours notice, Excel Physical Therapy & Sports Medicine will collect \$25 for a missed appointment on my credit card below.
2. If I make a payment by check that has insufficient funds, I authorize Excel Physical Therapy & Sports Medicine to collect the non-payment, plus \$20.00 returned check fee, on the card below.

NAME ON CARD _____			
<input type="radio"/> CREDIT CARD		<input type="radio"/> DEBIT CARD	
<input type="radio"/> MASTERCARD	<input type="radio"/> VISA	<input type="radio"/> DISCOVER	<input type="radio"/> AMEX
CARD NUMBER _____			
EXPIRATION DATE _____			
SIGNATURE _____		DATE _____	