

PAYMENT AGREEMENT

Payments are due at the time of service. Due to the frequency of therapy appointments a payment card MUST be saved on file.

Choose One:

I would like to save my credit card on file and be charged at time of service

I would like to save my credit card on file and be charged a lump sum at the end of each week

Circle One: Amex Visa MC Discover HSA

Credit Card #: _____ Exp Date: _____

CVV: _____ Zip Code _____

By signing this document you are authorizing Michigan Orthopaedic Rehab/Michigan Hand Therapy to charge your card for any *copays, deductibles, and/or cancelled/missed appointments.*

Patient/Parent/Guardian

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____
(Print)
