STEVE KRAVITZ
PHYSICAL THERAPY

CRANIOSACRAL THERAPY
VISCERAL MOBILIZATION
LYMPHATIC DRAINAGE
MYOFASCIAL RELEASE

Credit Card Authorization Form

Name (as it appears on the credit card) _____

Credit Card Type _____ MasterCard _____ Visa _____ American Express

Credit Card Number _____

CVV Code _____ (3 digit code on back of the card)

Expiration Date _____

Billing Address _____

_____

_____

Financial Acknowledgement

I understand that I am financially responsible for all charges on the day of each treatment whether or not these charges are covered under insurance. I hereby authorize the release of all information to secure payment. A minimum of 24 hours notice for cancellation is required and this office will be notified by 12:00 (noon) the day before any scheduled treatments if cancellation is necessary. Patient is responsible for payment for any missed or late cancellations of appointment (s) as described above. If payment is not made for any treatment or missed appointments, I authorize the use of my credit card on file for processing payment.

Signature Patient/Guardian : _____ Date: _____

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