Athletic & Rehabilitation Center
www.arckc.com

Automatic Payment Authorization

Client or Patient Name: ________________________________

Client or Patient Date of Birth: ________________

I authorize Athletic & Rehabilitation Center to automatically charge my credit/debit card: (Choose the option that applies)

☐ *Amount of all outstanding charges due for self pay accounts each month*

☐ *$_________._____ per month for balances owed after insurance reconciliation*

I understand that I am in full control of my payment and that I can discontinue the Automatic Payment plan at any time by notifying Athletic & Rehabilitation Center at the location listed above. I understand refund periods are limited to ninety (90) days and are reviewed on a case by case basis. I also understand that Athletic & Rehabilitation Center will consider my credit card information as private and will not disclose the information to anyone who is not an employee of Athletic & Rehabilitation Center.

The credit/debit card to be charged is:

Type: (Circle) Visa MasterCard Discover American Express

Card Number: ______________________________

Expiration Date: _______________

Name On Card: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Phone Number: ( ) _______-__________

______________________________ ___________

Signature (must match name on card) Date

For a complete listing of our clinic locations please visit our website
www.arckc.com

2/2009