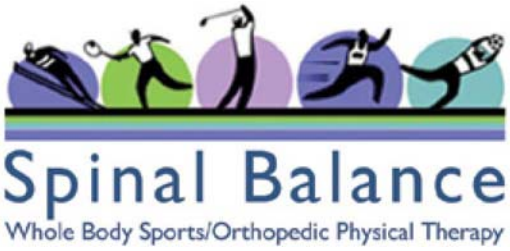

Vincent Romviel, R.P.T., Manual Therapist

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Credit Card Authorization

As an added convenience, you may wish to leave a credit card imprint to facilitate payment of treatment charges. To initiate this service, please sign the statement below:

I authorize Spinal Balance Physical Therapy to keep my signature on file and to charge my credit cardfor balances of charges not covered by insurance, co-payments, or no show/late cancellation fees.

I understand that this form is valid unless I cancel the authorization through written notice to Spinal Balance Physical Therapy.

(Please DO NOT SIGN if you DO NOT wish to keep a credit card on file).

Print Name:_____

Signature: _____

Date:_____