FEE FOR SERVICE/OUT OF NETWORK AGREEMENT

We/I enter into agreement to pay Potential Physical Therapy, LLC. for services rendered and acknowledge that I/we are solely responsible for financial reimbursement for our/my physical therapy sessions. We/ I agree to pay Potential $150.00 for the initial evaluation and $120.00 for each additional visit. *

*Payment is due at time of service.

Signature___________________________________Date________

CREDIT CARD INFORMATION

Account# ____
Expiration_______________________________ CVC#______________

Name as it appears on card____________________________________

Billing Address____