FULL RANGE HEALTH SERVICES®
Your Life. Your Goals. Your Way.

Tel: 610.241.2685
Fax: 877.732.7311
WWW.FULLRANGEHEALTH.ORG

# PRE-AUTHORIZATION FORM

**I authorize (Full Range Health Services dba Full Range Physical Therapy, LLC) to keep my signature on file and to charge the below listed card for the following:**

____ The Invoiced “Amount Due”

____ Recurring Charges for – Out Patient Clinic Private Pay Rate

____ Recurring Charges for – House Call Private Pay Rate

____ Balance remaining after claims(s) is (are) resolved.

---

**Patient Name:** _____ **Card Holder Name:** _____

**Billing Address:** _____

**City/State/Zip:** _____

**Type of Card:** _____ **HAS/HRA/FSA** _____ **Debit** _____ **Credit**

**Card Number:** _____

**Expiration Date:** _____ **Security Code:** _____

**Signature of Card Holder:** _____ **Date:** _____