



I (we), the undersigned, authorize and request Ocean Recovery Centers Inc., to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

In the event that your insurance company pays you directly for Ocean Recovery Centers services rendered and billed on your behalf, you are responsible to provide such payment to Ocean Recovery Centers immediately, otherwise your credit card will be charged for the amount paid to you by your insurance company.

This authorization relates to all payments not covered by my insurance company for services provided to me by Ocean Recovery Centers.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give 60 days notification Ocean Recovery Centers, in writing and the account must be in good standing.

First Name:

Middle Name / MI:

Last Name:

Patient Signature:

Date: