

CREDIT CARD PAYMENT FORM

I authorize Regional Orthopedics to charge my credit card for balances of fees, if not paid by my insurance company within 30 days of requested payment (electronic or postage date). These charges may include but are not limited to co-payments, non-covered service and/or supplies and deductibles.

If the fees exceed \$200.00, we will make a courtesy call to inform you of the amount charged to your credit card.

Card holders name: \_\_\_\_\_

Card holders signature: \_\_\_\_\_

Card number: \_\_\_\_\_

Security Code: \_\_\_\_\_ Expiration date: \_\_\_\_\_

This information is confidential and will be used only for the payment of fees to Regional Orthopedics.