ADVANCED ORTHOPAEDIC SURGERY CENTER

CREDIT CARD PAYMENT FORM

Patient Name _____
Last first MI

I authorize Advanced Orthopaedic Surgery Center (AOSC) to charge my credit card for the balance of fees, if not paid by my insurance company within 45 days.

Date of visit _____

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

Card holder name _____

Card holder signature _____

Card type _____
(Discover card not accepted)

Card number _____

Code number on card _____

Expiration date _____

This information is confidential and will be used only for payment of fees to Advanced Orthopaedic Surgery Center (AOSC).

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