ADVANCED ORTHOPAEDIC SURGERY CENTER

LATE FEE NOTIFICATION FORM

DATE: ____________________

PATIENT NAME: ____

SIGNATURE: ____

I have declined the credit card payment option. I understand that if I do not pay after receipt of my first bill and it is necessary for Advanced Orthopaedic Surgery Center to bill me a second time, I will incur a $10.00 late fee.

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