

PATIENT EASY PAY CONSENT FORM

Patient Name: _____

Patient MRN: _____

I authorize Fullerton Orthopaedic Surgery Medical Group, Inc.

To charge my credit card for any out of pocket expense which may be my responsibility until paid in full. I understand that if the charge is not accepted by the credit card company, I will immediately make payment to the practice.

I understand that I may cancel this authorization through written notice to the practice named above at any time, but by doing so I acknowledge that the balance owing will be due and payable in full.

Responsible Party Signature:

(relationship if not patient: _____)

Cardholder Name: _____

Cardholder Address: _____

City: _____ **State:** _____ **Zip:** _____

Credit Card Company: _____

Account Number: _____ **Expiration Date:** _____

Cardholder Signature: _____ **Date:** _____