Midwest Orthopaedics at RUSH

CREDIT CARD / DEBIT CONSENT

(To be completed by office)

DATE:_____ DATE OF BIRTH:_____

PATIENT NAME:_____ SS# (last 4-digits):_____

ADDRESS:_____ EMAIL:_____

_____

We would like you to provide us with valid Credit Card or Bank information to facilitate the settlement of any balances that may be your responsibility after we have settled with your health insurance carrier. Sixty days after balances have been deemed patient responsibility, your Credit Card / Bank Account will be charged for the amount due. Please provide us with a voided check so we can verify bank account and routing information. You will be notified by email, if provided, a letter and/or phone of any outstanding balances prior to us charging your card or bank account at which time we will inform you of your payment options.

Deposit Type: (Check Type and Complete Information)

O ACH Withdrawal:

ABA Routing # _____ Acct# _____

Authorized Signature: _____ Date: _____
Please provide us with a voided check so we can verify your bank account and routing information

O Credit Card:

Cardholder Name _____
Last First MI

Credit Card Type: _____ Visa _____ Mastercard _____ Discover

Card Number # _____

Exp. Date: Month _____ Year _____

This authorization is valid up to the expiration date on the credit card

Authorized Signature: _____ Date: _____

MOR Witness: _____ Date: _____