



# Orthopedic & Sports Medicine Center

## Credit Card Installment Plan

PATIENT INFORMATION		
LAST NAME	FIRST NAME	MI
CARDHOLDER INFORMATION		
LAST NAME	FIRST NAME	MI
CARD TYPE <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover		
CARD NUMBER		SECURITY CODE (3 DIGITS)
EXPIRATION DATE MM/YYYY: _____/_____/_____		
CARDHOLDER SIGNATURE		
SELECT PLAN OPTION		
<p>For balances greater than or equal to \$100, but less than \$500, please apply unpaid balance in:</p> <input type="checkbox"/> three equal monthly payments <input type="checkbox"/> two equal monthly payments <input type="checkbox"/> one payment		
<p>For balances greater than or equal to \$500, but less than \$1,000, please apply unpaid balance in:</p> <input type="checkbox"/> three equal monthly payments <input type="checkbox"/> two equal monthly payments <input type="checkbox"/> one payment		
<p><input type="checkbox"/> For balances greater than or equal to \$1,000, but less than \$2,500, please apply unpaid balance in:</p> <input type="checkbox"/> six equal monthly payments <input type="checkbox"/> three equal monthly payments <input type="checkbox"/> two equal monthly payments <input type="checkbox"/> one payment		
<p>Please note: Balances less than \$100 will automatically be applied in one payment</p>		

Terms and conditions: Orthopedic & Sports Medicine Center (OSMC) requires that a valid credit card be provided upon patient registration. This card will be held as security for payment and will only be charged in cases where it has been indicated. Services may not be rendered without a valid credit card on file.

Authorization: I hereby authorize OSMC to use the credit card provided as indicated above. I understand that by signing this credit card authorization form that all charges as I have indicated will be placed on this credit card. This authorization is valid until the expiration date on the credit card.

\_\_\_\_\_  
Signature of cardholder

\_\_\_\_\_  
Date