PAYMENT INFORMATION FOR RESPONSIBLE PAYERS OR PATIENTS WISHING TO KEEP CREDIT CARD INFORMATION ON FILE.

This section is to be filled out by all patients. Please Print.

Patient Name: ______________________________________ Patient #: ____

Patient Address: ____

Patient Phone: ____

Patient Signature: **X**____

RESPONSIBLE PAYER INFORMATION

This section is to be filled out by responsible payers only

You are aware that OMG'S office policy is "Payment on the date of service." As the Responsible Payer, your signature below acknowledges that you are responsible for the balance in full of the above patient. All outstanding charges will be put on your credit card.

Responsible Payer Name: ____

Address: ____

RP Phone #: ____________________________ Relationship to patient: ____

Comments: ____

By my signature, I agree to be responsible for the above patient's OMG medical bills at time of service.

Responsible Payer Signature: **X**____

Please fill in your credit card information below.

CREDIT CARD INFORMATION

This section is to be filled out by the Responsible Payer or patients wishing to keep their credit card information on file.

Credit Card Holder Name (as it appears on card):

CC#: ______________________________________ Expiration Date: ____

Security Code #: ________________________ CC Holder's Phone: ____

Relationship to patient: ____

I, ____________________________, authorize OMG to charge the above credit card for any transactions incurred by (patient name): ___________________on his/her/my OMG account until I advise you otherwise in writing.

Credit Card Holder's signature: **X**____

Receptionist's Initials: __________________________________Date: ____

Receptionist: Kindly attach this form to patient's voucher for date of service. Thank You.

Responsible Payer Form/word/. EC 03/29/07