ORENTREICH MEDICAL GROUP

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

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PATIENT INFORMATION Please print clearly.

Patient Name: _____

Address: _____

Phone: _____

Affix patient label here.

Patient ID #: _____

First and Last Name: _____

RESPONSIBLE PAYER INFORMATION This section is to be filled out by the responsible payer.

Responsible Payer: ☐ Patient ☐ Other _____

The office policy of Orentreich Medical Group, LLP (OMG) 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 charged to your credit card.

Responsible Payer Name: _____

Address: _____

Responsible Payer Phone: _____ Relationship to patient: _____

Comments: _____

By my signature, I agree to be responsible for the above patient's Orentreich Medical Group, LLP charges at the time of service.

Responsible Payer Signature: _____

CREDIT CARD INFORMATION

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

Credit Card Number: _____ 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
Credit Card Holder Name

(patient name): _____ on his/her/my OMG account until I advise you otherwise in writing.

Credit Card Holder's signature: _____

OMG Receptionist initials: _____ Date: _____

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