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:_____

_____

Midwest Orthopaedics at Rush (ñMORò) would like you to provide us with a Credit/Debit Card or Bank Account information. This information will facilitate the settlement of any balances that may be your responsibility after we have settled with your health insurance carrier. Your signature below gives consent and authorizes MOR to charge your Credit or Debit Card / Bank Account for the outstanding balance due. You will be notified prior to us charging your Debit Card or initiating an ACH payment from your bank.

If a valid Credit/Debit Card or Bank Account information is not provided and you are scheduled to have surgery then you are responsible for the cash portion of any co-insurance or deductible, if the amount can be determined prior to surgery. If the balance cannot be determined at the time of scheduling, then a $500 deposit will be required to hold your surgical appointment. The $500 deposit will be applied to whatever patient balances are not paid by your health insurance carrier (such as deductibles, co-insurances, co-pays and/or non-covered services). If you have a High Deductible Plan you will be required to pay the remaining un-met portion of your deductible to hold your surgical appointment. If the insurance carrierôs benefits plus the amount on deposit exceed the amount owed for services, the difference will be refunded back to you.

O ACH Withdrawal

Last 4 digits of checking account #: _____

O Credit Card **O Debit Card**

Credit/Debit Card Type: Visa MasterCard Discover

Last 4 digits of card: _____ **Exp. Date**: Month _____ Year _____

Authorized Signature: _____ Date: _____

MOR Witness: _____ Date: _____