

COUNTRYSIDE ORTHOPAEDICS, PC
CREDIT CARD AUTHORIZATION FORM

In order for Countryside Orthopaedics, PC ("CSO") to accept and bill your credit card, please complete all fields, SIGN and date and fax it to (703) 858-1801 or return by mail to 19465 Deerfield Avenue, Suite 405, Leesburg, VA 20176-1707, ATTN: Billing Dept.

<input type="checkbox"/> ADD (New Participant)	<input type="checkbox"/> CHANGE (Credit Card and/or Account #)	<input type="checkbox"/> DELETE (Cancel Participation)
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One-Time Use:

I (we) hereby authorize Countryside Orthopaedics, PC (CSO) to charge the indicated credit card the amount indicated above. This is a one-time charge authorization. I am not authorizing CSO to setup my account within a recurring billing system. I understand that if I wish CSO to charge any balances to my credit card in the future, I will need to submit another authorization form at that time or choose the selection below. Further, I authorize CSO, if necessary, to initiate adjustments for any transactions credited/debited in error.

I (we) understand that should the regularly scheduled debit date fall on a weekend or a federal holiday, the debit shall occur on the following banking date. This authorization is to remain in full force and effect until CSO has received written notification of its termination by the applicant(s) in such a time and manner as to afford CSO a reasonable opportunity to act on it.

Recurring Billing:

I (we) hereby authorize Countryside Orthopaedics, PC (CSO) to charge the indicated credit card on a recurring basis as specified for payment of services provided. If CSO is unable to process my payment I will be responsible for an alternate payment arrangement and any resulting processing fees that may be incurred. Further, I authorize CSO, if necessary, to initiate adjustments for any transactions credited/debited in error.

I (we) understand that should the regularly scheduled debit date fall on a weekend or a federal holiday, the debit shall occur on the following banking date. This authorization remains in effect until such time as canceled by the applicant(s) in writing. This authorization is to remain in full force and effect until CSO has received written notification of its termination by the applicant(s) in such a time and manner as to afford CSO a reasonable opportunity to act on it.

FREQUENCY (Please check one)

Weekly Every Other Week Monthly

CHARGE AMOUNT and EFFECTIVE DATE

\$ _____ Effective Date: _____

CREDIT CARD (Please check one)

Discover MasterCard VISA American Express

ACCOUNT INFORMATION

Account # _____ Expiration Date _____

Name As It Appears on the Credit Card (Please Print)

Billing Address

Home Phone Work Phone Cell Phone

SIGNATURE

I acknowledge that I have read and agree to all of the above information, that I am the legal cardholder for this credit card, and that I am legally authorized to enter into this one time or recurring billing agreement with CSO. I guarantee and warrant all information provided is true and correct.

Cardholder's Signature Date

ALL INFORMATION KEPT ON FILE IS STRICTLY CONFIDENTIAL. THIS FORM IS TO BE RETAINED BY CSO AS A MATTER OF RECORD.
PLEASE RETAIN A COPY FOR YOUR RECORDS.