Midwest Orthopaedics at RUSH

SURGICAL FINANCIAL REQUIREMENT AGREEMENT

(To be completed by office)

DATE:_____ SURGICAL DATE:_____

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ SS#(last 4-digits):_____

_____

I am aware that I am required to provide Credit Card / Bank information or a $500 deposit to hold my surgical appointment. The $500 deposit will be applied to whatever patient balance is not paid by your health insurance plan (such as deductibles, co-insurances, co-pays and/or non-covered services). Any remaining balance will be requested at time of my follow up and/or further services outside of this financial agreement. Any refund due, will be returned after claims have been processed and paid by your health insurance carrier or applied to any other outstanding balances for services rendered by Midwest Orthopaedics at Rush.

Cash: _____

Check #: _____

Credit Card:

Cardholder Name _____
Last First MI

Credit Card Type: _____ Visa _____ Mastercard _____ Discover

Card Number # _____

Exp. Date: Month _____ Year _____

This authorization is valid up to the expiration date on the credit card

Authorized Signature: _____ Date: _____

_____ _____
Patient/Guardian Signature Date

_____ _____
MOR Witness Date