PATIENT FINANCIAL RESPONSIBILITY

PATIENT INFORMATION			
PATIENT NAME (LAST, FIRST, MI)	PATIENT ID	PATIENT DOB	DEVICE TYPE

We are committed to fully informing you at onset of the anticipated financial cost to you for our healthcare services before they are rendered to you. You are responsible for payments of your coinsurance and/or unmet annual deductible upon delivery and any non-covered services as well as self-pay items. Based on information supplied to us by your insurance carrier(s) and the estimated cost of services that your physician has prescribed, you are financially responsible for the following:

Payments

Date	Type	Description	Amount	Balance
			$	$

Balances $

Credit Card Payment Information

Credit Card #:

Expiration #:

CVV# (# on back of card):

Name on Card:

Notes/Comments:

Signature: ______________________________ Date: ______________________

I agree with the terms herein and give my permission to run my credit card for the amount owed.

Signature: ______________________________ Date: ______________________

Prosthetic & Orthotic Institute Representative

Rock Hill Location
223 S. Herlong Ave Suite 110
Rock Hill, SC 29732
803-980-5080 Fax: 803-980-5083

Pineville Location
105020 Park Rd
Suite 170
Charlotte, NC 28210
704-697-1105 Fax: 704-544-3438

Lancaster Location
901 W. Meeting St. Suite 102
Lancaster, SC 29720
803-283-8774 fax: 803-283-8780