



GOLDEN STATE ORTHOPEDICS & SPINE

CREDIT CARD PAYMENT FORM

Patient Name: _____

Invoice #: _____

Payment Amount: \$ _____

Credit Card Type: Amer Express Discover MasterCard Visa

Name on Credit Card: _____

Credit Card Number: _____ Exp Date: _____

Security Code: _____

ON BACK OF CARD

ADDRESS

ADDRESS LINE 1

ADDRESS LINE 2

CITY

STATE

ZIP

FOR OFFICE USE ONLY. PATIENT DOES NOT COMPLETE THIS PART.

Name of Person Calling: _____

Relationship to Patient: Self Spouse Other

Patient NextGen Account Number: _____

What is Payment For?

Payment on Acct Surgery Deposit Forms /Medical Records Imaging

Taken By: _____ Date: _____