Dear Patient,

Your insurance will be billed for applicable charges for today's service. By signing this form, you agree that any remaining balance due as the patient's responsibility will be charged to your credit card. Should there be any remaining balance after your credit card is charged, Dr. Orbuch will bill you and you will be responsible for paying these remaining charges.

I certify that this is my credit card and that I am legally authorized to give permission for its use. By signing this form, I authorize Dr. Orbuch to charge my credit card. I agree to pay in accordance with my credit card issuer agreement. In the event that there are any problems with my credit card payment, I agree to pay all collection costs and attorney's fees incurred in attempting to collect on the account balance.

_____ _____

NAME SIGNATURE

_____/_____/__20_____

DATE