NYU Langone Health

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Professor of Orthopedic Surgery
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Department of Orthopedic Surgery

CREDIT CARD AUTHORIZATION FORM
TELEHEALTH

I, _____**,** herewith authorize the office of Dr. John G. Kennedy at NYU Langone Health, to charge the credit card listed below for any balances due related to my office visit. I am aware that any additional services rendered other than the visit itself will be charged and billed for separately. Namely any injections, orthotic fittings, PRP, Shockwave Treatment etc.

New Patient Consult: $600.00
Follow up: $350.00.
You will be responsible for **payment** in full upon date of service.

Depending on the state you are in, the billing department will will submit a claim on your behalf. Please note that if your state is eligible for a claim to be submitted for telehealth, all the office will do is submit the claim. As the patient, you must track the claim and notify the office if any additional paperwork is needed to be sent it for the completion of the claim. Please make sure to obtain a claim number and fax/address if you are requesting for the office to send notes in on your behalf.

The practice DOES NOT submit claims to Medicare or Medicaid as we are opted out with both companies.

Amex, Visa, Master Card and Discover are accepted by the practice.
It is the patient's responsibility to keep the credit card information on file current until all balances have been paid in full. The card listed below is the official card that will be used for treatment payments, and in the case that I am unable to check-out with the office, will be processed for the amount of the visit (New Patient: $600; Established Patient: $350).

You will be charged a $100.00 **delinquency fee** for any declined transactions.

FULL NAME (as it appears on the card): _____

CREDIT CARD NUMBER: _____

MASTER CARD (___) VISA (___) AMERICAN EXPRESS (___) DISCOVER (___)

SECURITY CODE: _____

EXPIRATION DATE: _____

PATIENT SIGNATURE: _____

DATE: _____

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