



**Carolina
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Orthopaedics**

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... Improving the health of our communities

PAYMENT AGREEMENT

Patient _____

Responsible Party _____

Account# _____

I, _____ agree to pay **Carolina Regional Orthopaedics** the
sum of \$ _____ weekly/bi-weekly/monthly on my account balance of
\$ _____.

Payment is due by the _____ of the month, beginning, _____ 2012.

I will mail my payment in each month. _____ or, I authorize CRO to
(Initials)
automatically run my payment each month, by option below. _____
(Initials)

Visa MasterCard

Credit Card#: _____

Expiration Date: _____

Name Listed on Card: _____

(Please Print) By choosing the credit card option, your card will be billed each month for your convenience.

Signature _____

Date _____

Witness _____