

6144 Route 25A
Building C, Suite 13
Wading River, NY 11792
Ph: 631-886-2844



Island Rheumatology
and Osteoporosis, PC

46 Little East Neck Road
Suite 2
Babylon, NY 11702
Ph: 631-539-0588

Credit Card Payment Form

Date: _____	Name of Patient: _____
Patient's Account #: _____	Amount to be Paid: _____

Credit Card Information	
Name on Credit Card: _____	
Credit Card #: _____	
Expiration Date: _____	Three or Four Digit Security Code: _____
** The security code for Visa or Mastercard is on the back of the credit card.	
** The security code for American Express is on the front of the credit card.	

- I Authorize to pay the above amount
- I Authorize to use this card on file for future payments
- I Authorize to pay the above amount **and** use this card on file for future payments

Name of Patient /Legal Representative (specify relationship): _____

Signature of Patient /Legal Representative: _____

Date: _____

PLEASE FAX COMPLETED FORM TO 631-886-2842

THANK YOU!