



Johns Hopkins Otolaryngology-Head and Neck Surgery Medical Second Opinion Program

Payment Authorization

SERVICES REQUESTED:

_____ Otolaryngology-Head and Neck Surgery Medical Second Opinion \$ 550.00
 _____ Pathology Interpretation (add'l \$250.00 per interpretation) \$ _____
 _____ Radiology Interpretation (add'l \$250.00 per interpretation) \$ _____

TOTAL \$ _____

METHOD OF PAYMENT: _____ VISA _____ MasterCard _____ Discover _____ American Express

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Expiration Date			--		
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Security Code			
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NAME *(as it appears on your credit card)*

ADDRESS _____ **APT** _____

CITY _____ **STATE** _____ **ZIP** _____

I authorize Johns Hopkins Otolaryngology-Head and Neck Surgery to charge the above amount for services requested through the Medical Second Opinion Program. I acknowledge that I am an authorized user of this credit card and assume the risks and liabilities associated with its use.

SIGNATURE _____ **DATE:** ____ / ____ / ____

FOR OFFICE USE ONLY

Medical Record Number (MRN)									
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JHM Physician's Name:

- Specialty Dept: _____
- Pathology Dept: _____
- Radiology Dept: _____

Date of Service: ____ / ____ / ____