ASSOCIATED SURGICAL AND MEDICAL SPECIALISTS
3000 Cliffwood Road, Suite 100 • Chester, NJ 07930
908-879-4000

Date: ______________

MR #: ______________

Patient Name: ____ $ ______________

Amount: ____ Dollars

To be applied as follows:

Co-Pay / Co-Insurance: $__________

Self-Pay For Today: $__________

Apply To Balance: $__________

☐ Cash

☐ Check # ____________________

☐ VISA / MC / DSCVR (please circle)

☐ Phoned in payment: ____________

Card #: ______________________________

Exp Date: ______________________________

Last Three Digits on Back of Card: ____________

Your Receipt - Thank You

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