

RETURNED CHECK ITEM

Date:

To:

Re: Date of service _____

Your check # _____ in the amount of _____ was returned to us for insufficient funds. A \$15 return check fee is being applied to your account. Remit payment by either *cash or credit card* to our office no later than ___/___/20___ to avoid additional penalties.

Total \$ _____

See enclosed copy of returned item

Please advise us if you would like your check returned or destroyed.

Make your payment by one of three ways:

Pay by Phone: Call (951) 279-0777. Have your credit card ready.

Send Credit Card info: Name on Card _____

Card # _____

Exp. Date ___/___

Signature _____

Stop by our office: STAR Physical Therapy, 1820 Fullerton Ave. suite 320, Corona, CA. 92881.

Once again, to avoid further penalties we must receive payment by ___/___/20___.

Account Representative

Date