



1415 Wesley Drive
Salisbury, MD 21801
410.912.7000 (p)
410.912.4202 (f)

CREDIT REFUND REQUEST FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

REFUND DETAILS

I, the undersigned, am requesting a refund for the credit balance on the above patient(s) account(s).

Amount of Credit (if known): \$ _____

CHECK PAYABLE TO

Name the check should be payable to: _____

DELIVERY METHOD

Please select one:

Mail Check - Mail to the following address:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Pick Up in Office - (Valid photo ID will be required at time of pickup.)

Preferred contact number when check is ready: _____

ACKNOWLEDGMENT

I understand that:

- Refunds are processed after all insurance payments have been finalized.
- Processing time may take up to 20 business days.
- The credit balance will be verified prior to issuing a check.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____