Patient Easy Pay Consent

I authorize _____ to keep my
(name of health care provider)

signature on file and to charge my:

☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

❑ Balance of charges not paid by insurance within ninety (90) days and not to exceed $_____ for:

- ❑ this visit only
- ❑ all visits this year

❑ Recurring charges (ongoing treatments) of $_____ every _____ from _____ to _____
(frequency) (date) (date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

Patient name: _____

Cardholder name: _____

Cardholder address: _____

City: _____ State: _____ ZIP: _____

Account number: _____

Expiration date: _____ Security Code: _____
(on back of card)

Cardholder signature: _____

Date: _____