

## Patient Easy Pay Consent Form

Patient Name: \_\_\_\_\_  
Last First Middle Initial

I authorize \_\_\_\_\_  
Provider Name

To charge my payment card for the balance of fees not paid by my insurance company within 90 days.

\_\_\_\_\_ This visit, only, not to exceed \$ \_\_\_\_\_

\_\_\_\_\_ All visits in the next year, beginning \_\_\_\_/\_\_\_\_/\_\_\_\_, not to exceed \$ \_\_\_\_\_

\_\_\_\_\_ Recurring charges, date(s) of service \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_, not to exceed  
\$ \_\_\_\_\_ \_\_ monthly \_\_ semimonthly \_\_ weekly \_\_ per visit

\_\_\_\_\_  
Card Holder Name

\_\_\_\_\_  
Card Holder Signature

\_\_\_\_\_  
Card Holder Number

\_\_\_\_\_  
Card Expiration Date

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Today's Date

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