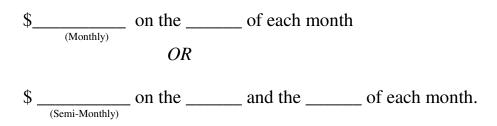
PATIENT EASY PAY CONSENT

I authorize **AUBURN FAMILY HEALTH CENTER, P.C.** to keep my signature on file and to charge my Bank Card (Debit/Credit) account for:

Balances of past and future charges not paid by insurance. I agree to pay:



I assign my insurance benefits to the provider listed above. I understand this form is valid until my Bank Card expires unless I cancel the authorization through written notice to the health care provider.

Patient Name:		
Cardholder Name:		
Cardholder Address:		
City:	State:	Zip:
Card Name:		(Debit or Credit)
Account Number:		
Expiration Date:		3 Dig Code:
Cardholder Signature:		_ Date: