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:

$_____ on the _____ of each month
(Monthly)

OR

$ _____ on the _____ and the _____ of each month.
(Semi-Monthly)

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: _____ Type of Card: _____
(VISA, MC, Discover, American Express) (Debit or Credit)

Account Number: _____

Expiration Date: _____ 3 Dig Code: _____

Cardholder Signature: _____ Date: _____