ATLANTIC EYE CENTER

207 Stone Harbor Blvd
CMCH, NJ 08210

ATLANTIC EYE CENTER OPTICAL
Cape Cataract Center

200 New Road
Linwood, NJ 08221

PATIENT EASY PAY CONSENT FORM

I,_____ authorize **Atlantic Eye Center** to charge my credit/debit card for the balance NOT paid by my insurance (copays, deductibles, coinsurance amounts, and optical materials.) I give permission to only charge an amount per month not to exceed $100.00, unless otherwise authorized by me. I assign my insurance benefits to the provider listed above. I understand that this form can only be used when filled out completely and is valid unless I cancel this authorization in written notice to Atlantic Eye Center.

Please note if you decline to participate in our Easy Pay Consent a $10 billing fee will be assessed for future bills on your account.

Patient Name _____

Cardholder Name_____

Cardholder Address_____

City_____State_____Zip_____

Credit Card Number_____ **Visa** **Master Card** **Discover**

Expiration Date_____ 3 Digit Security Code _____

Cardholder Signature_____

Date_____ E-Mail Address _____

Do you want a receipt? Yes_____ No_____ If yes, would you like it by fax, email or mail?
(please circle one)

___ I DECLINE the Easy Pay Consent _____
(must be completed) **Signature**

6/13