EASY PAY CONSENT FORM

ATLANTIC EYE CENTER

ATLANTIC EYE CENTER OPTICAL

Cape Cataract Center

I,_____ authorize **Atlantic Eye Center** to charge my credit/debit card for the balance NOT paid by my insurance (copays, deductibles and coinsurance amounts.) 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. I wish to be notified before my credit/debit card is charged. Yes____ No___ _____.

Print name and date.

******Please note effective 01/02/2013, If you decline to participate in our Easy Pay Consent a $10 billing fee will be assessed for future bills on your account.******

PLEASE PRINT

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**

_____

signature

(must be completed) 2019