Colorado Springs Family Practice

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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

DOB:_____

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.