PATIENT EASY PAY CONSENT

I authorize ____
(Name of Health Care Provider)

to maintain my credit/debit on file for the balance of charges not paid by insurance within 90 days.

Not to exceed $_____________

___Weekly ___Semi-Monthly (1st and 15th) ___Monthly (1st of the month)

Date(s) of Service ______/______ to _____/______

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

____
Cardholder Signature Date

Patient Name____

Cardholder Name____

Cardholder Address____

City__________________________________State_____________Zip__________

Card Number _______-______-______-_______ Exp. Date ______-______ C Code______

Circle One: Visa / MC / AMEx / Discover Email Address____________________________

Primary Phone _________________________ Secondary Phone _________________________

Please return to Natalee Menge
nmenge@emergela.org
7784 Innovation Park Drive, Baton Rouge, LA 70820

(To be completed by The Emerge Center staff)

Patient Acct # ____________________________