PATIENT EASY PAY CONSENT FORM

Please complete and return this form to our office for us to bill your Visa or MasterCard automatically for any balance owing on your account at the time of service and/or past due.

Today's Date: _____/_____/_____

Patient Name: _____
(Print)

Parent/Guardian Name: _____
(Print)

I authorize Columbia Associates in Psychiatry to charge my Visa or MasterCard credit card for any out of pocket expense which may be my responsibility until paid in full. I understand that if the credit card company does not accept the charge, I will immediately make payment to the practice.

I understand that I may cancel this authorization through written notice to the practice named above at any time, but by doing so I acknowledge that the balance owing will be due and payable in full.

Responsible Party Signature: _____

Relationship, if not patient: _____

We accept Visa or MasterCard

Today's Date: _____/_____/_____

Cardholder Name: _____

Cardholder Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Credit Card Company Name: _____

Account Number: _____

Expiration Date: _____/_____ **Security Code:** _____
(three digits on back of the card)

Cardholder Signature: _____