Patient Easy Pay Consent

I authorize ____ to
(Name of Health Care Provider)
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: ____/____ Security Code: _____

Circle One: Visa / MC / AMEX / Discover Email Address: ________________________________

Primary Phone: ______________________ Secondary Phone: ______________________

Please return to:
Emerge Center Accounting
accounting@emergela.org
7784 Innovation Park Drive, Baton Rouge, LA 70820

Below to be completed by The Emerge Center staff

Patient Acct # ________________________