



EZ Pay Authorization

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| Patient Name: |
| Patient Acct Number: |
| Patient Address: |
| Patient City, State, Zip |
| Payment Type: ACH CREDIT |
| Amount Authorized: |

I hereby authorize this office to keep this signature on file and to charge my credit card or checking account for the balance of charges not paid by my insurance within 90 days, not to exceed the amount shown above for this visit only.

I hereby 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.

_____ Date: _____
Signature