Center for Eye Health, Inc.
1030 President Avenue
Fall River, MA 02720

PATIENT EASY PAY CONSENT

I authorize:

_____
(name of health care provider)

to keep my signature on file and to charge my credit card account for :

[ ] Balance of charges not paid by insurance within 90 days and not to exceed $ for:

[ ] this visit only

[ ] all visits this year

[ ] all visits from _____ to _____
(date) (date)

[ ] Recurring charges (ongoing treatment) of $ _____

every _____from _____to _____
(frequency) (date) (date)

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.

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____State: _____ Zip: _____

Account Number: _____Expiration Date: _____

Cardholder Signature: _____Date: _____

MASTERCARD – DISCOVER – VISA – AMERICAN EXPRESS