Easy Pay Program Consent

Date:_____

In an effort to make the necessary heath care more immediately accessible for our patients, our office offers patients the option to pay their deductibles over time if needed, through the Easy Pay program. By completing this consent, your high deductible will be broken down into smaller payments automatically charged to your credit card account until the charges have been settled. This eases the sudden burden of a high deductible which needs to be met. All credit card information will be kept in strictest confidence, with only one office member having access to said information. Receipts will also be available for any flex plan reimbursement programs you may have through your work.

I authorize the office of Dr. Scott Burdge to incrementally charge my credit card for the balance of charges not paid by my insurance within 90 days following treatment.

Not to exceed: $50.00 $100.00 or _____ per week month or_____.

I understand this form is valid for one year unless I cancel the authorization through written notice to this office.

Patient Name:	**Signature:**	
Cardholder Name: (if different)	**Signature:**	
Cardholder Address:		
City:	**State:**	**Zip:**
Card type (circle one): Visa	**Master Card**	**American Express** **Discover**
Credit Card Number:		
Expiration date:		