

## Patient Easy Pay Consent

I authorize **Sitka Medical Center** to keep my signature on file and charge my Visa/Master card account for:

Balance of charges not paid by my 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 treatments) of \$\_\_\_\_\_ every \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_  
(frequency ex: monthly) (date) (date)

Specific date(s) you would like payment posted: \_\_\_\_\_  
(ex: 5<sup>th</sup> of every month)

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 my provider.

Patient name(s): \_\_\_\_\_ account number(s): \_\_\_\_\_

Cardholder name: \_\_\_\_\_

Cardholder address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Card account number: \_\_\_\_\_

Expiration date: \_\_\_\_\_ Security Code (3 or 4 digit #): \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_