Patient Easy Pay Consent

Date:_____

Woman's Group of Meridian, PLLC

I authorize Woman's Group of Meridian, PLLC to keep my signature on file and to charge my Visa or Mastercard account for:

[ ] My account balance of $_____ on _____ plus
(date)
any charges incurred after _____.
(date)

[ ] My account balance of $_____ on _____ plus
(date)
any balance of charges incurred after _____ not paid
(date)
by my insurance.

[ ] My account balance of $_____ on _____ .

A payment of $_____ will be charged to my Visa / Mastercard

on the 15th day of every month starting _____.

Patient Name: _____ Acct # _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Expiration Date: _____

Cardholder Signature: _____ Date: _____

Notes: _____

Financial Counselor: _____