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 _____ (date) to _____ (date)

☐ Recurring charges (ongoing treatments) of $_____ every _____ (frequency ex: monthly) from _____ (date) to _____ (date)

Specific date(s) you would like payment posted: _____ (ex: 5th 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: _____