

# Children's Eye Center

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PRACTICE LIMITED TO

Pediatric Ophthalmology and Strabismus

(512) 458-1922

## Easy Pay Consent Form

I authorize Children's Eye Center to maintain my credit / debit card on file for the balance of charges not paid by my insurance company.

Amount not to exceed \$ \_\_\_\_\_  Monthly  Weekly  Bi-weekly  
 Annually  Per Visit

For date(s) of service: \_\_\_\_\_ to \_\_\_\_\_

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

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

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Cardholder Name

\_\_\_\_\_  
Cardholder Address

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

\_\_\_\_\_  
Card Number - - - - Exp Date /

\_\_\_\_\_  
V Code

\_\_\_\_\_  
Account #

\_\_\_\_\_  
Chart #