

# Patient Easy Pay Consent Form

Patient Name: \_\_\_\_\_  
                            Last                            First                            Middle Initial

I authorize Eve Lievonen, PHD, LCSW to charge my credit card for payments remaining on my account or delinquent payments that are 30 days mature without a formal payment agreement in place. This charge could be for the balance of fees not paid by my insurance company within 30 days from the balance of charges after an explanation of benefits is received from my insurance company, which may include co-pays, co-insurance deductible balances, etc. Or it could be due to missed appointments that were either canceled too late, no shows, or balances owed for miscellaneous expenses (i.e letters written on my behalf where fees were discussed, returned check charges).

I understand that this form is valid until the expiration date of my charge card listed on this form, unless I cancel the authorization through written notice.

Name on the card \_\_\_\_\_ Phone \_\_\_\_\_

Billing address \_\_\_\_\_

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

Master card/  Visa /  American Express

CCV \_\_\_\_\_

Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Card Holders Signature \_\_\_\_\_ Date \_\_\_\_\_