PATIENT EASY PAY CONSENT

I authorize **LOREE S. NICHOLAS, D.D.S., P.C.** to keep my signature on file and to charge my Bank Card (Debit/Credit) account for balances of past and future charges not paid by insurance after 30 days of billing.

I assign my insurance benefits to the provider listed above. I understand this form is valid until my Bank Card expires unless I cancel the authorization through written notice to the health care provider.

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Card Name: _____ Type of Card: _____

(Visa/ Master Card) **(Credit/ Debit)**

Account Number: _____

Expiration Date: _____ 3Didgit Code: _____

Cardholder Signature: **Date:**