

Patient Easy Pay Consent

I authorize **Pacific Coast Dermatology (Dr. T. Anthony Hoang-Xuan, FAAD)** to maintain my credit/debit card on file for the balance of charges not paid by insurance within 90 days.

Not to exceed \$ _____

- Annually
- Monthly
- Weekly
- Per Visit

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.

Card Holder Signature

Date

Patient Name _____

Cardholder Name _____

C/C Billing Address _____

Card Number _____ - _____ - _____ - _____

Exp Date ____ / ____

V Code _____