



Women's Health Specialists

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Tucson, AZ 85712
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copperstateobgyn.com

PATIENT EASY PAY CONSENT FORM²

I authorize Copperstate OB/GYN Associates, LTD. to maintain my credit, or check on file for the balance of charges not paid (by insurance) as agreed below.

If I do not make a payment by check by the 15th of the month, after an EOB (Explanation of Benefits) is received I authorize Copperstate OB/GYN Associates LTD. to deduct:

NOT TO EXCEED \$_____ monthly,

For Service Dates ____/____/____ to ____/____/____

Until the balance is paid off in full.

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 (once the outstanding balance is paid in full).

I also understand that if I change charge cards, I will supply the provider above with the new credit card authorization.

Cardholder Signature Date

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip Code: _____

Credit Card Number: _____ - _____ - _____ Exp Date: _____

V Code: _____

²Pre-EOB