Clarity Clinic

PATIENT EASY PAY CONSENT FORM

(This form is not optional)

I authorize Clarity Clinic to charge my credit/debit card for late fees as outlined in the "Policies and Procedures" Form.

I authorize Clarity Clinic to charge my credit/debit card for all charges and services not paid by my insurance company within 90 days of services rendered including co-pays and no-show fees unless discussed otherwise with the office staff.

BILLING INFORMATION					
Name on Card					
Card Number					
Expiration Date		Type of card (check one)			
		VISA ☐	MasterCard ☐	AMEX ☐	Discover ☐
CVV Code					
Billing Address					
City			State	Zip	

I understand that this form is valid without expiration unless I cancel this authorization by notice in writing submitted to Clarity Clinic.

SIGNATURE			
Signature (patient, parent or legal guardian)		date	
Witness signature		date	