ARIZONA DIGESTIVE HEALTH

Easy Pay Authorization

Our “Easy Pay” plan gives you the opportunity to place a credit/debit card on file for any balance of charges not paid by your insurance or any non-covered charges, not to exceed the deductible/co-insurance/co-payment amounts.

Your credit/debit card will not be charged until you have been notified by our office with the amout owed and given the opportunity to make payment by a different method (check, cash, money order).

Patient Name: _____

Cardholder’s Name (if different from above): _____

Please Select: ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover ☐ Debit

Card Number: _____ Exp: _____

Security Code (3 or 4 digits): _____

Authorization to Pay:
I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I understand and accept the conditions of the “Easy Pay” plan.

_____ _____
Signature Date

Cardholder’s Signature (if different from above): _____

For Office Use:

Account #: _____ Date of Procedure:_____

Procedure: _____

Estimated Patient Responsibility: _____ Deductible: _____ Coins: _____

Notes: