

Patient Easy Pay Plan and Consent

I, _____ authorize JOHN S. ROLLINS, M.D., Medical Corporation to charge my credit card for payments due including co-pays, deductible and all non-covered charges. This also covers charges billed but not paid by insurance within 90 days. I understand that, as a courtesy to me, my primary insurance company will be billed by John S. Rollins' office, but that timely payment for the above charges is my responsibility, based on my contract with my insurance company and my agreement herein with the office of John S. Rollins, M.D.

I understand that under this Easy Pay Plan, the "Patient Responsibility Amount" shown on my Insurance Company's Explanation of Benefits (EOB) will be simply transferred to my credit card listed below.

Automatic payment will be transferred to my credit card:

- Upon Doctor's receipt of Insurance EOB (Office's Preferred Option)
- End of month Semi-monthly
- Weekly Per Visit

Options: Do Automatically

Please call, email or fax first and leave a message, I might want to send a check.

(If no return response is received within 5 calendar days, my credit card will be automatically charged.)

I assign my insurance benefits to the provider listed above.

I authorize John S. Rollins, M.D. to maintain my credit account on file for "Easy Pay" purposes only.

I understand that this form is valid for one year unless I cancel the authorization by written notice to John S. Rollins, M.D. and sent to 2505 Samaritan Drive, Suite 209, San Jose, CA 95124

Cardholder Signature

Date

Patient Name		Contact me at:	Home, work, cell, fax or email
Cardholder Name			
Cardholder Address			
City		State	Zip
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard			
Credit Card Number			