CENTRAL FLORIDA PAIN & REHAB CLINIC
www.cfprc.com

3727 N. Goldenrod Rd. #103
Winter Park, FL 32792
Phone: 407-673-9533
Fax: 407-673-1442

EASY PAY CONSENT FORM

PLEASE COMPLETE AND RETURN THIS FORM TO OUR OFFICE FOR US TO BILL YOUR CREDIT CARD AUTOMATICALLY FOR ANY BALANCE OWED ON YOUR ACCOUNT AT THE TIME OF SERVICE AND/OR PAST DUE.

IN THE EVENT THAT THE CREDIT CARD PROVIDED DOES NOT BELONG TO THE PATIENT, THE CARDHOLDER *MUST* COMPLETE THIS FORM AND ATTACH A LEGIBLE COPY OF THEIR VALID ID.

DATE _____

PATIENT INFORMATION

PATIENT NAME _____ ACCOUNT # _____

ADDRESS _____

ADDRESS CITY STATE ZIP CODE

CONTACT _____

HOME PHONE CELL PHONE OTHER

I AUTHORIZE ***CENTRAL FLORIDA PAIN & REHAB CLINIC*** TO MAINTAIN MY CREDIT CARD INFORMATION AND CHARGE IT FOR ANY OUT OF POCKET EXPENSE WHICH MAY BE MY RESPONSIBILITY UNTIL PAID IN FULL.

I UNDERSTAND THAT IF THE CREDIT CARD COMPANY DOES NOT ACCEPT THE CHARGE, I WILL IMMEDIATELY MAKE PAYMENT TO THE PRACTICE BY CASH OR DEBIT CARD.

I UNDERSTAND THAT I MAY CANCEL THIS AUTHORIZATION THROUGH WRITTEN NOTICE TO THE PRACTICE NAMED ABOVE AT ANY TIME, BUT BY DOING SO I ACKNOWLEDGE THAT THE BALANCE OWED WILL BE DUE AND PAYABLE IN FULL.

I ALSO UNDERSTAND THAT IF MY CREDIT CARD INFORMATION CHANGES FOR ANY REASON, INCLUDING REPLACEMENTS, EXPIRATIONS OR IF IT IS LOST OR STOLEN, I WILL PROMPTLY CALL THE OFFICE AT **(407)-673-9533** TO UPDATE MY INFORMATION.

_____ _____

CARDHOLDER SIGNATURE **DATE**

CREDIT CARD INFORMATION

CARDHOLDER NAME _____

ADDRESS _____

ADDRESS CITY STATE ZIP CODE

CREDIT CARD FINANCIAL INSTITUTION _____

CREDIT CARD TYPE ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS CREDIT CARD # _____

EXPIRATION DATE _____ / _____ SECURITY CODE _____ (3 digits on back of the card)

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