

Patient Easy Pay Plan and Consent

I, _____ authorize Family Medicine at Lowry, PC (FMAL), 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 FMAL, 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 FMAL.

I understand that under this Easy Pay Plan, the “Patient Responsibility Amount” when on my Insurance Companies Explanation of Benefits (EOB) will be simply transferred to my credit card listed below.

Automatic payment will be transferred to my credit card:

- Upon Doctors receipt of Insurance EOB (preferred)
- End of the month
- Per visit

Options:

- Do automatically
- Please call and leave a message or email me thru REACH MY DOCTOR. I may choose to send a check. (If no response is received within 5 calendar days, my credit card will be automatically charged.)

I assign my insurance benefits to the medical office listed above. I authorize FMAL to maintain my credit account on file for “Easy Pay Plan” purposes only.

I understand that this form is valid unless I cancel the authorization by written notice to:

**Family Medicine at Lowry, PC
130 Rampart Way Suite 150
Denver, CO 80230**

Cardholders Signature

Date

Patient Name

Contact phone number:

Cardholder Name (Please Print)

Cardholder Address (Please Print)

City, State, Zip (Please Print)

VISA MASTERCARD

CREDIT CARD # _____ **EXP:** _____ **SECURITY CODE:** _____