WILLIAM D. CALDWELL, M.D., P.A.
1305 W. 34TH ST. SUITE 210
AUSTIN, TX 78705
512-454-0406

PATIENT EASY PAY CONSENT FORM

I authorize **DR. WILLIAM D. CALDWELL'S OFFICE** to maintain my credit/debit card on file for the co-pays/ balance of charges not paid by my insurance company.

Not to exceed $ ____________ without consent from the patient/ insured.

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider. I agree to notify William D. Caldwell, M.D. in advance of my credit/debit cards expiration.

Patient Name ____

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Cardholder Name ____

Cardholder Signature ____

Cardholder Billing Address ____
City ______________________ State ______________ Zip ____________

Card Number ______-______-______-______ Expiration Date ________ V-Code____

Would you like to be notified by email of charges submitted to your credit card?

O Yes Email address to notify ____

O No

Date Signed ____

(This confidential information will be kept in a securely locked place in our office.)