

Patient Easy Pay Consent Form

Patient Name: _____

I authorize _____
Provider Name

- To charge my payment card for my member responsibility as determined by Humana.
- To credit my payment card account when an overpayment of my member responsibility has occurred.

____ This visit, only, not to exceed \$ _____

____ All visits this calendar year, not to exceed \$ _____

____ Recurring charges, date(s) of service ____/____/____ to ____/____/____
\$ _____ monthly ____ semimonthly ____ weekly ____ per visit

Card Holder

Signature

Card Number

Exp. Date

Today's Date

I assign my insurance benefits to the provider listed above. I understand this form is valid for one year unless I cancel the authorization through written notice to the health care provider.
