CITYVIEW PSYCHIATRY, P.A.
Debra Atkisson M.D, P.A.
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DrDebra.net

Patient Easy Pay Consent

I authorize the office of Dr. Debra Atkisson to keep my signature on file and to charge my credit card for payments on the balance of charges for services that I am responsible for.

I authorize the charge of $_____________, not to exceed $_________________.

- ☐ Annually
- ☐ Semi- monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Per Visit

I Understand that this from is valid until I cancel the authorization through written notice to the health care provider.

_________________________________ _________________________
Cardholder Signature Date

Patient Name	Patient Phone Number
Cardholder Name (as it appears on the card)	
Cardholder Street Address	City State Zip
(Circle one) VISA MasterCard Discover	
CC#________________________________ Exp. Date ____________________	3 digit code______________