Aida R. Coffey MD
1010 RR 620 South, Suite 108, Lakeway, TX 78734
Office: (512) 496-7284 or Fax: (512) 263-9975

PATIENT PAYMENT CONSENT FORM

Patient Name: _____

Name on Card if Different: _____

Card Number: _____ -- _____ -- _____ -- _____ Exp. Date _____

Card Holder's Billing Address for Monthly Card Statements:

Security Code:_____

_____

Street City/State Zip Code

I authorize Aida R. Coffey MD to charge my

credit card for professional services as follows:

_____ Full Fee for Service _____

_____ Co-pay Amount or Fees Towards Insurance Deductible _____

_____ Triplicate Fees_____

By signing this form, you also agree that you will be charged automatically for any no-show or cancellation less than 24 hours in advance in the amount of $50.00.

Please be aware that unless an agreement is negotiated with the above provider (or representative) all outstanding balances not paid within 30 days, after a bill is sent or the insurance company has notified you or this office of your balance, will be charged to your credit card.

Card Holder's Signature: _____ Date: _____

Please note that all information will be kept confidential and that information will only be used to obtain payment for services.