Cincinnati Center for Improved Communication, Inc.

Services in Speech, Language, and Language-Based Learning Disorders

PATIENT EASY PAY CONSENT

I authorize Cincinnati Center for Improved Communication, Inc. to charge my credit card for: monthly charges/co-payments/, and/or deductibles due.

- ☐ **Monthly**
- ☐ **Weekly**
- ☐ **Per Visit**

Date(s) of service _____/_____/_____ to _____/_____/_____.

I assign my insurance benefits to the provider listed above. I understand that this form is valid until the expiration date on my card or until services are no longer rendered.

_____ _____

Cardholder Signature **Date**

Patient name			
Cardholder name			
Cardholder address			
City	**State**		**Zip code**

- ☐ **Debit Card**
- ☐ **HSA**
- ☐ **FSA**
- ☐ **Credit Card** **Visa** **MasterCard** **American Express**

Credit card number _____/_____ **Expiration date**_____

3-4 digit CW number (found on back of card immediately following charge card number, or for American Express, found on front of card)

A 3.5% processing fee will be added to all credit card transactions (Visa/MasterCard/American Express).

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