Aishling Obstetrics and Gynecology, SC

Electronic Payment Authorization Consent Form

By signing the below agreement, you are Authorizing Aishling Obstetrics and Gynecology, SC to automatically process a charge on your credit/debit card up to $150.00 on balances in which your insurance applies to your responsibility. Before any payments are ran an email will be sent from Billing@aishlingobgyn.com informing you of the balance, amount and date in which the payment will automatically run. Once the email is sent, you will have 24 hours to notify the billing department not to run the payment.

I, ______________________________ hereby authorize Aishling Obstetrics and Gynecology to automatically process any balance up to $150.00 on my Credit / Debit card.

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Patient Name

______________________________ ______________________
Patient / Guarantor Signature Date

Type of Card: ☐ Credit ☐ Debit

Card Number: ______________________________ Exp Date. ______________

SVC Number: ______________________

Email: ____