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PATIENT EASY PAY CONSENT

I authorize the office of Larry Gruenwald, M.D. & Ann Marie Comandatore, M.D., PA to keep my signature on file and charge my:

Visa# _____ exp. date _____ 3 digit code on back of card _____
Amex# _____ exp. date _____ 4 digit code on front of card _____
MC# _____ exp. date _____ 3 digit code on back of card _____
Disc# _____ exp. date _____ 3 digit code on back of card _____

For all visits until the Expiration Date of card, not to exceed \$ _____ per month

Patient's Name: _____

Date of Birth: ____/____/____
____/____/____
____/____/____

Cardholder's Name (print): _____

Cardholder's Address : _____

Cardholder's Phone #: _____

Relationship to Patient (print): _____

Cardholder's Signature: _____

Date: _____

**Please be advised that this form is valid until we receive a written cancellation.*