



SOUTHERN ORANGE COUNTY PEDIATRIC ASSOCIATES

"Great Care for Great Kids"

EZ-PAY CONSENT FORM (OPTIONAL)

I authorize Southern Orange County Pediatric Associates to keep my signature on file and charge my
 Visa Mastercard for the following:

All office visit copayments and the balance of charges after an explanation of benefits is received from my insurance company, which may include co-insurance, deductibles, balances, etc., and is not to exceed \$ _____ for each child per date of service.

I assign my insurance benefits to Southern Orange County Pediatric Associates and I understand that this form, which replaces any prior EZ-PAY forms, is valid until the expiration date of my charge card listed on this consent form, unless I cancel the authorization beforehand with *written notice*.

Children to which this consent applies:
(NAMES)

(ACCOUNT NUMBERS)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name on card: _____ Phone: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ - _____ - _____

Expiration Date: _____ 3-digit authorization number: _____

Card Holder
SIGNATURE: _____ DATE: _____

Southern Orange County Pediatric Associates
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