

RANDALL V. SELLERS, MD
ADULT PSYCHIATRY *
CHILD & ADOLESCENT PSYCHIATRY *
FORENSIC PSYCHIATRY *
* BOARD CERTIFIED, ABP&N

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Patient Easy Pay Consent

I authorize: Randall V. Sellers, MD to keep my signature-on-file and charge my credit / debit card:

OPTION I At the time of service:
From ___/___/___ to ___/___/___
Not to exceed \$ _____

OPTION II For the balance of charges remaining within _____ days,
Not to exceed \$ _____

OPTION III For recurring charges of \$ _____ per _____
Beginning on ___/___/___ for _____ payments

Credit Card : Visa®, MasterCard®, Discover® and American Express®

Cardholder Name: _____

Account Number: _____

Expiration Date: _____

zip code : _____

Street Address: _____

Card code: _____

Cardholder Signature: _____ **Date:** _____

Preauthorized Credit Card Signature "On File"

Patient Name