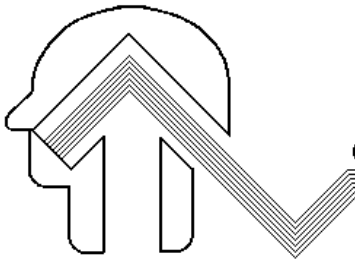

CEDAR CENTRE

P.O. Box 1408
Cedar Rapids, IA 52406-1408
(319)-365-3993

PATIENT EASY PAY CONSENT

I authorize Cedar Centre Psychiatric Group to keep my signature on file to charge my Visa/MasterCard/Discover account for:

- One time only in the amount of $_____ to be run on _____.
- Recurring charges of $_____ to be run _____ from _____ to _____.
- Recurring charges of $_____ to be run at time of service from_____ to _____.

I understand that this form is valid unless I cancel the authorization through written notice to Cedar Centre Psychiatric Group.

Patient Name: _____ Account #: _____

Cardholder name: _____ Type of card: _____

Cardholder address: _____

City: _____ State: _____ Zip: _____

Card #: _____ Expiration date: _____

Cardholder signature: _____ CVV #_____

Receipt: _____ Date: _____