

Breast 'N Baby Lactation Services, Inc.
Carol Chamblin, RN, APN, IBCLC
525 Tyler Rd., Ste. L-2, St. Charles, IL 60174

Easy Pay Agreement

PATIENT NAME: _____

I authorize Carol Chamblin, RN, APN, IBCLC to keep my signature-on-file and to charge my credit/debit card: for any balance not paid by my insurance, not to exceed amount of co-payments/co-insurance and deductibles for Breast 'N Baby Lactation services for all services rendered. I understand that I will be notified by a statement or letter, prior to any charges being applied to my credit card. At that time, I may choose another form of payment.

I assign my insurance benefits for the indicated services to Carol Chamblin, RN, APN, IBCLC, the provider listed above.

Patient Name: _____

Card Holder's Name: _____

Card Holder's Billing Address: _____

Credit Card Type:

Visa Mastercard

Credit/Debit Card Number: _____

Expiration Date: ____/____ 3 Digit Security Number: _____

Card Holder's Signature: _____

Today's date: _____

Preauthorized Credit Card Signature on file for Health Care Expenses

Thank you!