**Larry Gruenwald, M.D., F.A.A.P.**
**Ann Marie Comandatore, M.D., F.A.A.P.**
**Mara Sterio, M.D., Ph.D., F.A.A.P.**
**Andrea Alexander, M.D., F.A.A.P.**
**Sharon Spiteri, M.D., M.P.H., F.A.A.P.**
**Yanina Meshko, M.D., F.A.A.P.**
**Shruti Ramesh, D.O., M.P.H., F.A.A.P.**

90 MILLBURN AVE., SUITE 104, MILLBURN, NJ 07041
Billing Tel # (973) 378-2230 • Billing Fax # (973) 378-7993

# EASY PAY PROGRAM

Easy Pay is a convenient way to have your bills automatically paid with a credit card of your choice. It allows our patients to keep their credit card information on file, authorizing the billing office to charge agreed amounts on a monthly basis. The information is always kept confidential.

Easy Pay accounts are reviewed and charged on the 30th of each month, providing the 30th is not a weekend or holiday, in which case accounts are charged the preceding business day. Receipts will be furnished upon request.

Please be assured that the billing office has been offering this convenient service for a number of years with many satisfied participants.

Should you wish to participate with Easy Pay, please complete this authorization form and return it in the green envelope.

BILLING DEPARTMENT

| DATE | ACCT # | AMOUNT | DATE | ACCT # | AMOUNT |
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Last Update: 02/04/2020

Larry Gruenwald, MD and Ann Marie Comandatore, MD, PA

# PATIENT EASY PAY CONSENT

I authorize the office of Gruenwald & Comandatore, MDs 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 the entire patient balance.

☐ for all visits until the expiration date of card, not to exceed $_____ per month.

☐ for date of service _____ amount $_____ date card to be charged on _____.

Patient's Name: _____ Date of Birth: ____/____/____

_____ ____/____/____

_____ ____/____/____

Cardholder's Printed Name: _____

Billing Address: _____

Cardholder's Phone #: _____

Relationship to Patient (Please print): _____

Cardholder's Signature: _____ Date: _____

**Please be advised that this form is valid until we receive a written cancellation request.**
**It will be kept in a locked and secure file and will be shredded once the agreement is fulfilled.**

| For office use only |
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