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AUTHORIZATION OF PAYMENT BY CREDIT CARD

I, \_\_\_\_\_ authorize Allergy & Asthma Consultants to charge the  
(Patient Name)  
following amount(s) to the selected credit account.

\_\_\_\_\_ For all deductibles or co-insurance co-pays allowable by my insurance  
company *for this visit only*.

\_\_\_\_\_ For all deductibles or co-insurance co-pays allowable by my insurance  
company for *all visits*.

\$ \_\_\_\_\_ Monthly

To pay with your credit card please complete:

- Visa: Account # \_\_\_\_\_ Security Code \_\_\_\_\_
  - Mastercard: Account # \_\_\_\_\_ Security Code \_\_\_\_\_
  - American Express # \_\_\_\_\_ Security Code \_\_\_\_\_
- Exp. Date: \_\_\_\_\_ Signature: \_\_\_\_\_