



JOHN V. BOSSO, MD, FAAAAI, FAAAAI

LOURDES B. deASIS, MD, MPH, FACP, FAAAAI

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*.

To pay with your credit card please complete:

- Visa: Account # _____
- Mastercard: Account # _____
- American Express # _____

Exp. Date: _____ Signature: _____