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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: _____