CONSULTANTS IN
ALLERGY & ASTHMA CARE

1160 Park Avenue West, Suite 3 South, Highland Park, Illinois 60035 office847.432.0200 fax 847.432.0201
www.allergyasthmacare-doctor.com

Card on File: Authorization Form

Information to be completed by cardholder:
The undersigned agrees and authorizes Consultants in Allergy & Asthma Care, LLC to save the credit card indicated below on file. A **credit card is required** to schedule an appointment for a new patient and on Saturdays for a new patient or testing appointment.

The credit card number is encrypted in our system and it will not be charged without the card holder's knowledge. **We will charge your credit card for any unpaid balance over 90 days.** When necessary, we will work with you to set up a payment plan.

Medical Practice: Consultants in Allergy & Asthma Care, LLC

Patient's Name (Print): _____

Name As It Appears
On The Credit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits of Card: _____

Expiration Date: _____

Security Code: _____

I understand and agree to the above terms, I also agree that this authorization will remain in effect until the expiration of the credit card or until the balance on my account has been paid.

_____ _____

Cardholder's Signature Date