



CONSULTANTS IN  
**ALLERGY & ASTHMA CARE**

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[www.allergyasthmacare-doctor.com](http://www.allergyasthmacare-doctor.com)

**Credit Card on File: Authorization Form**

**Information to be completed by cardholder:**

A **credit card is required** to schedule a new patient, testing or a challenge appointment. The undersigned agrees and authorizes Consultants in Allergy & Asthma Care, LLC to save the credit card indicated below on file.

The credit card number is encrypted in our system and it will not be charged without the card holder's knowledge. **However, we will charge your credit card for any unpaid balance over 90 days.** You are responsible for charges not covered by your health insurance plan. 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 balance on my account has been paid.

\_\_\_\_\_  
Cardholder's Signature

\_\_\_\_\_  
Date