

**THE ALLERGY and ASTHMA CLINIC**  
**Andrew C. Engler, M.D.**  
**June Y. Zhang, M.D.**  
**Brooke K. Leon, N.P. Elisabeth M. Denker, N.P.**

**Dear Patient:**

**The Allergy and Asthma Clinic is offering a new service to our valued patients. We are pleased to inform you that we are now offering the option of having monthly payments automatically charged to your preferred credit card. Per your instructions, this would authorize us to charge either your balance in full each month or a specific amount that you determine.**

**If you are interested in this service, kindly provide us with the information requested below, and we will initiate monthly charges for your convenience. Once we receive your permission, we will keep this information, which we treat as strictly confidential, on file in our office for automatic billing.**

**Patient Name** \_\_\_\_\_ **Account #** \_\_\_\_\_

**Name as it appears on credit card** \_\_\_\_\_

**Billing Address** \_\_\_\_\_

**City, State, Zip** \_\_\_\_\_

**Phone number** \_\_\_\_\_

**Card (Visa, MC, AX)  
number** \_\_\_\_\_

**Expiration date** \_\_\_\_\_

**Specific instructions/amount to be charged** \_\_\_\_\_

**Please charge my card on the 1<sup>st</sup> of the month \_\_\_\_\_ on the 15<sup>th</sup> of the month \_\_\_\_\_**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Please feel free to contact us with any questions or concerns. We look forward to hear from you.**

**Thank you for your continued loyalty to the Allergy and Asthma Clinic.**

**290 Baldwin Avenue San Mateo, CA 94401**  
**Ph: (650)343-4597 Fax: (650)343-3402**  
**www.theallergyclinic.com**