THE ALLERGY and ASTHMA CLINIC
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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_____**cvv#**_____
Security code _____
Please charge my card on the 1st of the month _____ **on the 15th 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.

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