Illinois Allergy & Asthma Specialists

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PAYMENT ON FILE AUTHORIZATION

Cancellation and Delinquent Account Policy

I authorize Illinois Allergy and Asthma Specialists ("IAAS") to charge my payment method for any outstanding balances when due. The authorization also relates to all payments not covered by my insurance company.

To best service the schedules of our patients: for office visits canceled less than 24 hours in advance, or failure to keep an appointment, patients may incur a $50 charge. All accounts not paid within 60 days will be forwarded to a collection agency.
Credit Card type:

- Visa
- MasterCard
- AMEX (online payment only)
- Discover (online payment only)

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

I hereby acknowledge receipt of the medical services, authorize IAAS to bill the above credit card for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in your agreement with the credit card issuer.

I authorize IAAS to process the above credit card and to keep my signature and payment information secure as "card on file." I will be notified when my credit card is charged. I understand this authorization will remain in effect until the expiration of the credit card account. I may revoke this form by submitting a written request to the medical practice. I have read and understand the financial policy of this medical office and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice without prior written notice.

Signature: _____ Date: _____

Printed Name: _____

Billing Address: _____

City: _____ STATE: _____ ZIP CODE: _____

<u>This authorization is also valid for the following patients:</u>

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

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