Metropolitan Asthma and Allergy, PC
34 Sycamore Ave. Suite 1A
Little Silver, NJ 07739
Phone: (732) 383-5554
Fax: (732) 383-5495

# Financial Agreement & Credit/Debit Card Authorization Form

I understand that I am responsible for all fees associated with each visit and the healthcare services provided. The required fee includes the amount NOT covered by insurance, including co-pays and deductibles.

Once an insurance plan has paid its portion of the required fees for the treatment provided, an Explanation of Benefits (EOB) will be provided by the insurance company. The EOB will explain the amount of the fee paid by insurance and state the balance due if any.

I understand that if I do NOT have insurance coverage that the required fee must be paid at the time of the visit.

By providing my credit/debit card information to Metropolitan Asthma & Allergy and signing below, I authorize Metropolitan Asthma & Allergy to charge the below provided card for the amount not covered by insurance.

## Credit/Debit Card Information:

Complete Credit Card Number:_____

CVV Number:_____ Expiration:_____

Credit Card Billing Name & Address:_____

_____

_____ _____

Signature of Credit Card Holder Printed Name

Date: _____