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

Credit Card on File Authorization

Metropolitan Asthma & Allergy PC requires a Credit Card on file for paying the portion of your services that are patient responsibility such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure.

I _____, authorize and request that Metropolitan Asthma & Allergy, PC charge my credit card for the balance due that my health plan has identified as my financial responsibility. This authorization relates to all charges not covered by my insurance company for services provided to me. My card will remain securely stored for future use to collect payments.

This authorization will remain in effect until revoked by me in writing.

Patient's name:_____ DOB:_____

Please keep my credit card on file and charge my account to pay for charges not paid by my insurance plan.

Patient/Guardian signature:_____

Date:_____

Credit card information:

Card type: ____Amex ____Visa ____Mastercard ____Discover

Is this card a Flexible Spending/Health Savings card? Yes No

Credit Card Number :_____

Expires:_____ CVV_____

Cardholder name:_____

Cardholder Address:_____