Allergy, Asthma & Sinus Care Center
9701 Landmark Parkway Dr. | Suite 207 | St. Louis, MO 63127
Phone 314.849.8700 | Fax 314.849.8737

CREDIT CARD PRE-AUTHORIZATION

I authorize Allergy, Asthma & Sinus Care Center to keep my signature on file and to charge the credit card selected below if my account becomes delinquent or overdue.

Charges may be made on the following patients to keep account current:

_____ _____/_____/_____

_____ _____/_____/_____

_____ _____/_____/_____

_____ _____/_____/_____

_____ _____/_____/_____

❍ MasterCard ❍ Visa ❍ Discover ❍ American Express

Cardholder's Name_____

Cardholder's Address_____

City / State / Zip Code_____

Credit Card Number_____

Expiration Date _____/_____/_____ Security Code (CVC)_____

Cardholder's Signature_____ Date_____/_____/_____