ADVANCED ALLERGY
IMMUNOLOGY & ASTHMA P.C

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Advanced Allergy, Immunology & Asthma requires a $500.00 deposit for holding new patient appointment time slots. You are asking us to reserve one full hour out of our schedule. If you cancel or miss your new patient appointment, this fee is NON-refundable. When you do keep your appointment time, this fee is applied to your initial visit charges. (Credit card info is kept very safe and confidential).

If you are not sure you are going to be able to keep your new patient appointment, please do **NOT** schedule at this time.

Sincerely,

Advanced Allergy, Immunology & Asthma, P.C.

Appointment Date/Time: _____

Patient Name(s) _____

Billing Address _____ Phone Number _____

City, State, Zip Code _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

C.C. Number _____

Expiration Date _____ V Code _____

PLEASE NOTE: By booking a new patient appointment time, you are hereby agreeing to forfeit your deposit if the appointment is not kept for any reason. By signing above I authorize A.A.A.I to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Signature: _____ Date:_____