



Kansas City Allergy & Asthma Associates, P.A.

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENT

This authorization is for the patient responsibility portion of your bill. For contracted insurance this will be the amount remaining after insurance payment and adjustment. We acknowledge that the transactions to your account must comply with the provisions of U.S. law.

Credit card # _____

Expiration Date _____

Master Card/ Visa (Circle One)

CHECK TYPE OF ACCOUNT

Debit Checking Savings

I authorize Kansas City Allergy and Asthma Associates to keep my signature on file, and to charge the credit card or bank account identified above for the balance of charges not paid by my insurance company as indicated below:

- For all treatment.**
- Payment Plan (installment payments)**
- Balance of allergy/asthma or allergy injection services charges.**

***At any time, I may elect to pay my account in full to prevent this authorization from being activated.**

***I should receive an Explanation of Benefits from my insurance company within 45 days showing my balance.**

***I will be notified by billing statement before charges are sent to my credit card or bank account.**

***I may set up a payment plan for large balances.**

I assign my insurance benefits to Kansas City Allergy and Asthma Associates (KCAA). I understand that this form is valid for one year unless I cancel the authorization through written notice to KCAA.

SIGNATURE

DATE

(Print Name)