

**Princeton Allergy Asthma
Credit Card Authorization
Fax to: 609-252-0037**

Patient's Full Name: _____

Date of Birth: _____

Patient's Billing Address _____

Name on credit card: _____

Circle One: Visa Mastercard

Card # _____

Exp. Date _____

Amount Authorized to my charge card: _____

I authorize Princeton Allergy & Asthma Associates., P.A. to charge my credit card.

Signature: _____

Date: _____