



Tullyview Allergy, P.C.

1030 Reed Avenue, Suite 108

Wyomissing, PA 19610

Phone: 610-478-4033 Fax: 610-374-1115

Providing Allergy/Asthma/Immunology care for the entire family

NEW PATIENT BILLING POLICY

For New Patients who will have out of pocket expenses above and beyond their copay, we do request a credit card to be securely kept on file. All claims will be submitted to the insurance company, and once write-offs are taken, you will be sent an invoice for your patient responsibility. Please note that we will automatically charge the credit card listed below if invoices are not paid after they have reached 60+ days on their statement balance, or if payment arrangements have not been made. Please call our office once you receive an invoice if you would like to pay by credit card or set up a Payment Plan. Thank you.

Date: _____

Patient's Name: _____

Responsible Party: _____

Name on Credit Card: _____

Card Number: _____ *Type of Card:* _____

Expiration: _____ *CW#:* _____

Signature of Credit Card Holder/Responsible Party

For Office Use Only:	
Payment Plan	_____ Yes _____ No
Frequency	_____ Start Date _____
Amount	\$ _____

This sheet should be returned to the Practice Manager, to ensure PCI Compliance and Security, and to have data securely stored in patient chart.