DIANE L. OZOG, M.D., S.C.

130 S. Main Street - Suite 202
Lombard, Illinois 60148

1288 Rickert Drive - Suite 100
Naperville, Illinois 60540

Phone: (630) 652-0606 Fax (630) 652-9900

I _____ hereby authorize Diane L. Ozog, M.D., S.C. to charge my credit/debit card in full for any remaining balance when the following occurs:

1. 90 days of non-payment on a balance due for any account with Diane L. Ozog, M.D., S.C.

2. I am considered Self-Pay and responsible for payment in full at the end of each office visit and/or immunotherapy injection (allergy shot) I receive.

I understand the remaining balance will include charges for applicable copays, deductibles, and services not covered by my insurance company, which are my financial responsibility.

I will receive a receipt via mail for any charges applied to my debit/credit card **or** checking account. I further agree to hold Diane L. Ozog, M.D., S.C. harmless for any and all fees or interest I may incur as a result of this charge to my credit/debit card **or** checking account.

I agree to notify Diane L. Ozog, M.D., S.C. in writing of any changes to the debit/credit card account information I have provided within fourteen (14) days of the change becoming effective.

I understand if for any reason the remaining balance due can not be applied to the credit/debit card or checking account number I have provided, Diane L. Ozog, M.D., S.C. has the right to pursue other collection options, as allowed by State and Federal law. These options include, but are not limited to, placing the account in review for collection status, reporting account as delinquent to major credit bureaus, and/or initiating legal action to collect payment.

_____
Patient Name (print)

_____
Guarantor Name (print)

_____ Date _____
Guarantor Signature

1/2/13