# Alamo Asthma & Allergy Associates


## Drs. Michael & Adrianne Vaughn

115 Gallery Circle, Ste. 200, San Antonio, Texas 78258

Office (210)-499-0033 / Fax (210) 404-0926


## Request for Multi-Family Member Appointments (Same day)

Dear_____,

You are requesting to schedule two patient appointments on ___/___/____ for

_____ and _____.

In order to schedule these appointments, you must return this form agreeing to a $60.00 cancellation fee (**per** patient) for any missed appointments for any reason.

You may call to schedule your appointment once we have received this letter.

***I agree to billing the card provided for a $60.00 fee for each missed appointment(s).***

Name _____ Signature: _____

Date ___/___/____

Card type: ___ MasterCard/ ___ Visa/ ___Am. Express

Card # _____ Security code: _____

Expiration: ___/___