



PREAUTHORIZED CREDIT CARD FORM

Patient Name(s): _____

I authorize ***Burgess Pediatrics, Inc.*** to bill the card listed below as specified:

- per month per patient
- per year per patient

*By choosing to use a credit card instead of bank debit via ACH, I accept a 3% credit card surcharge on each payment.

Start billing on: ____/____/____

End billing when: 30 days after patient provides written cancellation

- Credit Card Type: VISA Discover
 MasterCard American Express

Card Number: _____

Expiration Date: ____/____ CVC _____

Cardholder Name: _____

Billing Address: _____

_____ Zip _____

Billing Phone: _____

Billing Email: _____

Cardholder Signature: _____ Date: _____

- Dr. Sarah G. Cueva. Dr. Margaret Miller Dr. James A. Cisco

401 Burgess Drive, Suite C, Menlo Park, CA 94025-3408

For contract/billing questions contact

Leigh Phillips: leigh@burgesspediatrics.com or call (650) 305-2039