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

Start billing on: ____/____/____
End billing when: 60 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