BURGESS PEDIATRICS

PARTNERS:
James A. Cisco, MD
Sarah G. Cueva, MD
Margaret M. Miller, MD MPH

Bank Transfer Authorization Form

I authorize Burgess Pediatrics to electronically debit my bank account for membership and vaccination fees on a recurring basis according to the terms of the membership agreement and as outlined below:

Terms of Recurring Billing:

Membership Start Date: _____ ☐ Annually ☐ Monthly

Bank Account Information

Account Holder Name: _____

Routing Number: _____ Account Number: _____

Billing Address: _____ Zip_____

Billing Phone:_____

Billing Email: _____

This payment authorization is to remain in effect until I, , notify Burgess Pediatrics in writing with 30 days notice of my wish to terminate my membership.

Signature: _____

Printed Name:_____ **Date:** _____

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