Cambridge Pediatrics, LLC

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BUDGET PAYMENT AGREEMENT FOR OUTSTANDING BALANCE

I authorize Cambridge Pediatrics, L.L.C. to charge my credit card for payments on the balance of charges for which I am responsible and to keep my signature on file.

Patient Name: _____

Patient D.O.B.: _____ **Patient Acct. #:** _____

Email address _____
(needed to create account at our website if you have not already done so)

Total Balance on account: _____

I authorize the charge of $ _____ **monthly to my credit card**

Visa / Mastercard Credit Card number: _____
(circle one)

Exp. Date _____ **3 Digit Sec.Code:** _____

Cardholder Name _____
(as it appears on card)

Cardholder Address: _____
House #/ Street City State/ Zip code

Charges will be placed on the _____ **day of each month until the balance is paid in full unless I cancel this authorization in writing. In order that a scheduled charge not be placed on my account, the written cancellation must be received by Cambridge Pediatrics five (5) business days prior to the scheduled payment date to allow time for processing. I understand it is my responsibility to ensure that the cancellation was received.**

_____ _____

Print Name of Authorizing Parent/ Guardian **Signature**

3500 Old Washington Road, Suite 101 Waldorf, Maryland 20602
Washington Line (301) 843-9236 Waldorf Line (301) 645-1133 Fax (301) 645-2369