Howard Baron, M.D.
Christopher Rhee, M.D.
Elizabeth Mileti, D.O.
Navneetha Unnikrishnan, M.B.B.S.
Jenna Diaz, M.D
Teresa Carroll, P.N.P.
Holly Brewer, R.D.N.

Pediatric Gastroenterology & Nutrition Associates

3196 S. Maryland Pkwy., Suite 309 Las Vegas, NV 89109
653 Town Center Drive, Suite 412 Las Vegas, NV 89144
702-791-0477 · FAX: 702-791-6831

CREDIT CARD AUTHORIZATION FORM

Please complete and sign this authorization form. We will bill your credit card automatically for the amount indicated. You may cancel this automatic billing authorization anytime, by calling our office.

Patient Information:

Patient Name:________________________________

PGNA Account Number:______________________________

Telephone:____________________________________

Payment Information:

I authorize Pediatric Gastroenterology and Nutrition Associates to automatically bill the card listed below as specified:

Amount:_______________________
(Enter the amount you want deducted each month)

Date:__________________________
(Enter the date of the month you would like this amount deducted)

Credit Card Information

Credit Card Type Visa MasterCard Discover

Credit Card Number_____________________________ Exp Date________________________

Cardholder's Name **(as shown on credit card)** CRV**(3 digits on the back of the card)**___________

____

Address on Cardholder's Statement Zip Code

_______________________________ __________________________

Cardholder's Signature Date

______________________________ ____________________________