F. Tuna Burgut
5345 Macarthur Blvd NW
Washington D.C. 20016
Phone: 646 386 7555
Email: drtunaburgut@gmail.com

Credit Card Authorization Form

Name of Patient:____________________________________

The office requires that patients and families keep a credit card on file as a back-up payment method in the event of bill non payment and missed appointments that were not canceled 48 hours (two business days) in advance of scheduled appointment time. If you have not indicated a request to make payments in an alternative form, your card will be charged automatically at the time of the session.

By signing below I grant permission to F. Tuna Burgut, MD to bill my credit card as per parameters outlined above.

[] Visa []MasterCard

[] American Express []Discover

Name of Card Holder:__________________________

Card number:_________________________________

Expiration date:_______________________ CVV number:___________________________

Billing zip code: :_______________

Signature:__________________ Date:_________