

Charge Card Authorization Agreement

I am authorizing Medical Databases to charge my charge card noted here... ☐ Visa ☐ MasterCard ☐ Discover

Card number _____

Expiration Date _____

Bank Name _____

On back of card immediately after your card number are three additional numbers. These numbers are _____. _____.

Billing address _____

for card _____

I am approving the amount of \$_____._____. This payment is for the following products and/or services:

I also fully understand that this payment is not refundable, that the charge may appear on my statement as coming from Scott Zeigen, M.D., and that I will not contest this charge.

Name on card _____

Your Signature _____

Email Address _____

Today's Date _____

MedDB, LLC

130 Almshouse Road, Suite 305 Richboro, PA 18954
Phone: 215-364-2676 FAX BACK TO: 215-357-7781