

**PAYMENT BY CREDIT CARD WITHOUT COMING TO THE OFFICE**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

If you wish to pay by credit card without coming to the office, fax this form to (714) 902-1101 or mail it to:

Pacific Center for Plastic Surgery  
3991 MacArthur Blvd. #320  
Newport Beach, CA 92660

**A COPY OF THE CARDHOLDER'S DRIVERS LICENSE AND A COPY OF THE  
CREDIT CARD (FRONT AND BACK) MUST ALSO BE SENT**

**\*\*TRANSACTIONS WILL NOT BE PROCESSED WITHOUT THESE\*\***

I authorize Pacific Center for Plastic Surgery, Inc. to charge \$ \_\_\_\_\_

To Credit Card number: \_\_\_\_\_

Card Verification Number: \_\_\_\_\_ (The last 3 digits on the signature portion of the back of the card for  
Visa, MasterCard and Discover)

Expiration Date: \_\_\_\_\_

For Services Provided to: \_\_\_\_\_

Patient Name

Phone Number Where We Can Reach You: \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_

**The card member acknowledges receipt of goods and/or services in the amount of the total shown hereon  
and agrees to perform the obligations set forth by the card member's agreement with the issuer.**

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