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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