

Credit Card Authorization Form

Image: Signature of Cardholder:	Payment C	Option (please check o	only one)		
Name of Patient:	🛛 Visa	Mastercard	Discover	Other (payment terms)	
Name of Patient:	Amount to	charge \$			
Name of Cardholder as it appears on the card:					
Street Address of Cardholder: City: I authorize the Bengtson Center for Aesthetics and Plastic Surgery to charge the agreed amount listed above to the credit card provided. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. Signature of Cardholder: Please provide a copy of the cardholder's driver's license or other type of photo ID. Additional information: Initials: Initials: Linitials: Linitials: Linitials: Linitials: Linitials: Linitials: Linitials: Linitials: Linitials:					
City: State: Zip: I authorize the Bengtson Center for Aesthetics and Plastic Surgery to charge the agreed amount listed above to the credit card provided. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. Signature of Cardholder: Date: * Please provide a copy of the cardholder's driver's license or other type of photo ID. Additional information: Initials: The below portion is to be cut off & shredded once the transaction is completely processed. Account Number: Exp. Date:	Name of C	ardholder as it appears	s on the card:		
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	The below	portion is to be cut of	ff & shredded once t	he transaction is completely p	processed.
Security Code: (3 digit on back of Visa, Mastercard and Discover)	Account N	lumber:		Exp. I	Date:
	Security C	ode:	(3 digit on bo	ack of Visa, Mastercard and Dis	cover)

Bradley P. Bengtson MD, FACS