



**Bengtson Center**  
for AESTHETICS & PLASTIC SURGERY

**Credit Card Authorization Form**

**Payment Option (please check only one)**

Visa       Mastercard       Discover       Other (payment terms)

Amount to charge: \$ \_\_\_\_\_

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

Name of Cardholder as it appears on the card: \_\_\_\_\_

Street Address of Cardholder: \_\_\_\_\_

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: \_\_\_\_\_

Security Code: \_\_\_\_\_ (3 digit on back of Visa, Mastercard and Discover)

**Bradley P. Bengtson MD, FACS**