MANDAL PLASTIC SURGERY CENTER, P.A. (R. 2/12/26)

CREDIT CARD AUTHORIZATION FORM

NOTE: **All card transactions will incur a 3% processing fee**. Amex NOT accepted. If using financing, higher processing fees may apply.. **Please fill out COMPLETELY**.

□ VISA □ MC □CARE CREDIT □Alphaeon □ Other (if authorized by practice) _____

Cardholder name as it appears on card _____
****Person using card must be authorized user.

Card number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Card expiration date _____ /_____ (enter all appropriate 0's)

4 Digit security code ___ ___ ___ ___ (when applicable)

Amount Authorized $ _____._____ (enter cents, write "00" if no cents) **Plus 3%**

Billing address associated with credit card (include street, state and zip code)
_____

Card Holder's Driver's License Number or valid photo ID
_____ (IMAGE required unless office has on file)

I am an authorized user of this card and authorize Mandal Plastic Surgery Center to charge the amount above. I understand that the amount charged is non-refundable. I also understand there may be a delay in processing the charges, depending on when my doctor's office receives this request.

Authorized Cardholder's Signature _____ Date _____/_____/_____

Fax legible copy to 561.238.0041 or scan and email to
concierge@mandalplasticsurgery.com