

MANDAL PLASTIC SURGERY CENTER, P.A. (R. 3/31/26)

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 _____

****CARDHOLDER MUST BE THE PATIENT RECEIVING TREATMENT AND THE 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