AUSTIN-WESTON

THE CENTER FOR COSMETIC SURGERY

EST. 1978

____
Patient #

____
Full Name of Patient

____
Pre-op Date

____
Surgery Date

____
Full Name of Card Holder

____
Billing Address of Card Holder

____
City, State, Zip Code

I, _______________________________ authorize the Austin-Weston Center for Cosmetic Surgery (name of credit card holder) to charge my credit card in the amount of: $______________________ for (Initial One) _____ Non Refundable Scheduling Fee; ____ Final Payment.

The 10% Non-Refundable Scheduling Fee is required when scheduling. I understand that the Scheduling Fee charged to my credit card is not refundable. Surgery cancellation within 3 business days prior to scheduled surgery date may result in a forfeiture of 50% of all surgery fees, OR fees and Anesthesia fees paid plus credit card processing fees.

____________ ___________ ___________
(Card Type) First 4 Digits Last 4 Digits

I understand that if I, the cardholder, am not the patient, that I must submit a copy of a Photo ID (Driver's license/Military ID/Passport) with this authorization.

I understand the 10% Non-Refundable Scheduling Fee Policy and Surgery Cancellation Policy explained above.

________________________________ ___________________________
Signature of Card Holder Date

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______________ ___________________________ ____________ ____________
(MC, Visa, Discover, AMEX) (Card Number) (Exp. Date) (Security Code)