The AUSTIN-WESTON CENTER for COSMETIC SURGERY

Patient #

Full Name of Card Holder

Full Name of Patient

Billing Address of Card Holder

Fraxel Date

City, State, Zip Code

I, _____ authorize the Austin-Weston Center for Cosmetic Surgery to charge my credit card in the amount of: $ _____

(name of credit card holder)

of which **$250 is a Non Refundable Scheduling Deposit.**

The Non-Refundable Scheduling Deposit is required when scheduling. I understand that the Scheduling Deposit charged to my credit card is not refundable.

(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 Deposit.

Signature of Card Holder

Date

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

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