Waldman Schantz Plastic Surgery
3288 Eagle View Lane, Ste 300
Lexington, KY 40509
859.254.5665
www.WaldmanPlasticSurger.com

# CREDIT CARD AUTHORIZATION FORM

I, _____ (please print name) hereby authorize Waldman-Schantz Plastic Surgery to charge the specified credit card for any surgical fees for payment _____.

**PAYMENT(S) DETAILS:**

A single payment in the amount of $_____ or,

All payments due to Waldman-Schantz Plastic Surgery described as follows:
(please find details of the payments required to Waldman-Schantz Plastic Surgery on the fee sheet. Fees are subject to change.)

Deposit Amount: $_____ Deposit date: _____
Payment Amount: $_____ Payment date: _____

**CREDIT CARD DETAILS:**

Card Type: Visa Mastercard Discover American Express

Card Number: _____

Expiration Date: _____

Name as it appears on card: _____

Billing Address: _____

Cardholder Signature: _____

I may be contacted by telephone during the day at _____ or during non-working hours at _____ if there are any questions or concerns.

By signing this form, I agree to pay the specified amount(s) as outline on this document. Please return it to Waldman-Schantz Plastic Surgery when making payment or fax to (859) 281-2685. Thank you for your assistance.

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