Bengtson Center
for AESTHETICS & PLASTIC SURGERY

Credit Card Authorization Form

Payment Option (please check only one)

☐ Visa ☐ Mastercard ☐ Discover ☐ Other (payment terms)

Amount to charge: $ _____

Name of Patient: _____

Name of Cardholder as it appears on the card: _____

Street Address of Cardholder: _____

City:_____ State:_____ Zip:_____

I authorize the Bengtson Center for Aesthetics and Plastic Surgery to charge the agreed amount listed above to the credit card provided. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Signature of Cardholder: _____ Date: _____

**** Please provide a copy of the cardholder's driver's license or other type of photo ID.***

Additional information: _____

_____

_____

Initials: _____

The below portion is to be cut off & shredded once the transaction is completely processed.

Account Number: _____ Exp. Date: _____

Security Code:_____ *(3 digit on back of Visa, Mastercard and Discover)*

Bradley P. Bengtson MD, FACS

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