MANDAL PLASTIC SURGERY CENTER, P.A. (rev. 3/20/21)

Anita Mandal, M.D.

2401 PGA Blvd., Ste. 146; Palm Beach Gardens, FL 33410

Credit Card Authorization Request (please fill out COMPLETELY)

Today's Date ____/_____/_____

I, the undersigned, am an authorized user of the following card and authorize Mandal Plastic Surgery Center, P.A. to charge this card in the amount below. I understand that the amount authorized and charged is non-refundable.

□ VISA □ MC □ AMEX □CARE CREDIT

Cardholder name as it appears on card _____

Name of Person using card (must be authorized user)

Card number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Card expiration date _____ /_____ (enter all appropriate 0's)

3 or 4 Digit security code ___ ___ ___ ___ (when applicable)

Amount Authorized $ _____._____ (enter cents, write "00" if no cents)

Billing address associated with credit card (include street, state and zip code)

_____

Card Holder's Driver's License Number _____ (A copy of your driver's license or other form of valid photo ID must accompany this authorization.)

I understand that the amount charged is non-refundable. I understand there may be a delay in processing the charges to my card depending on when my doctor's office receives the authorization request.

Authorized Cardholder's Signature _____ Date _____/_____/_____

If faxing, please fax to: Mandal Plastic Surgery Center, P.A. at 561.238.0041