

Michael C. Edwards M.D., FACS
Plastic Surgery

AUTHORIZATION FOR THE USE OF A CREDIT CARD/CHECK

I hereby authorize Michael C. Edwards, M.D., FACS to charge my credit card or use my signed check for fees for services rendered by Dr. Edwards and his staff for services to be performed upon:

Patient Name

Credit Card: MasterCard®
 Visa®
 American Express®
 Discover®
 Care Credit®

Credit Card Number: _____

Security Code: _____

Expiration Date: _____

Amount to be charged: _____

Billing Address: _____

Street

City

State

Zip Code

Cardholder Name: _____

Cardholder Signature: _____

Date Signed: _____

****PLEASE ATTACH AN ENLARGED AND LEGIBLE COPY OF YOUR DRIVER'S LICENSE WITH THIS FAX**

****PLEASE COMPLETE AND FAX BACK TO (702) 243-7923.**

****PLEASE CALL (702) 248-8989 FOR ANY QUESTIONS**

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