WESTLAKE
DERMATOLOGY
& Cosmetic Surgery

CREDIT CARD AUTHORIZATION

I, _____, hereby authorize Westlake Dermatology & Cosmetic Surgery to charge a one-time payment to my credit card.

Type of Card: ❑ Visa ❑ Mastercard ❑ American Express ❑ Discover

Credit Card Number: _____

Expiration Date: _____ CVC/Security Code: _____

Credit Card Billing Address:

_____

_____

Telephone Number: _____

Cardholder's Signature: _____

Notes: _____

Please complete, sign, and fax this form to: (512) 666-3767