roxbury
SURGERY CENTER

AUTHORIZATION TO CHARGE CREDIT CARD ACCOUNT

PATIENTS NAME: _____

CARDHOLDERS NAME: _____

BILLING ADDRESS OF CARD:

_____

_____

_____

_____

PHONE: _____

TYPE OF CREDIT CARD:

❑ AMEX ❑ VISA ❑ MASTERCARD

ACCOUNT NUMBER: _____

ACCOUNT SECURITY CODE: _____ EXPIRATION DATE: _____

PAYMENT AMOUNT: _____

I AGREE TO PAY THE ABOVE AMOUNT FOR SERVICES RENDERED

SIGNATURE: _____ DATE: _____

IF YOU CHOOSE TO PAY YOUR FEES BY CREDIT CARD PLEASE COMPLETE THIS FORM
AND EMAIL IT TO kworthylake@roxburysurgerycenter.com OR FAX IT TO 310-746-4663.