CREDIT CARD BILLING AUTHORIZATION

This letter authorizes Beverly Hills Plastic Surgery, Inc./BHPS, Inc. to charge as stated below, to the credit/debit card listed below.

Patient/Client Name: _____

Date: _____

Total Amount to be charged: _____

Cardholder Name: _____

Cardholder Address: _____

City/State/Zip: _____

Phone: _____

Other Information: _____

Card Type: [ ] American Express [ ] Visa [ ] Mastercard [ ] Discover

Card No. : _____ Exp. Date: _____ Sec Code: _____

Cardholder Signature: _____ Date: _____

I authorize this charge: [ ] one-time [ ] monthly [ ] Other, please specify: _____

Please attach a copy of the front and back of the credit card along with this form. Fax back to: 310-861-1160 OR email info@bhpsinc.com.