



Florida Facial Surgery Center

DR. JAMES GIFT BOARD CERTIFIED • AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY

Date ____/____/____

I, _____, hereby authorize Dr. James Gift to process a payment in the amount of \$_____ via my credit card (AMEX, Visa, Mastercard, Discover, CARE CREDIT).

Card # _____ Exp: _____ V-Code _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

This payment will be processed on: _____

Patient Name: _____

Patient Account #: _____

Name of Cardholder: _____

Signature of Cardholder: _____

**PLEASE ATTACH A COPY OF THE CARDHOLDERS STATE ISSUED PHOTO ID OR
DRIVERS LICENSE (FRONT/BACK)**

**THIS FORM MUST BE COMPLETELY FILLED OUT AND RETURNED TO OUR OFFICE
48 HOURS PRIOR TO YOUR SURGERY DATE**