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

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