



JAMES E. VOGEL, M.D., FACS

PLASTIC SURGERY

Credit Card Authorization Form

Sign and complete this form to authorize the office of Dr. James E. Vogel to make a one time debit to your credit card listed below.

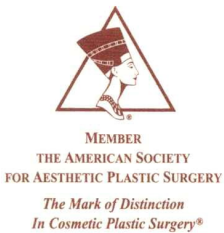
By signing this form you give us permission to charge your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

4 Park Center Court
Suite 100
Owings Mills, MD 21117

(410) 484-8860
FAX: (410) 484-2566

www.DrVogelPlasticSurgeon.com

BOARD CERTIFIED
American Board of Plastic Surgery



Please complete the information below:

I _____ authorize the office of Dr. James E. Vogel to charge my
(full name)
credit card account indicated below for _____ on or after _____.
(amount) (date)

This payment is for _____
(description of goods/services)

Billing Address _____
Phone# _____
City, State, Zip _____
Email _____

Account Type:	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> AMEX	<input type="checkbox"/> Discover
Cardholder Name	_____			
Account Number	_____			
Expiration Date	_____			
CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX)	_____			

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.