Rotemberg Plastic Surgery, PLLC

DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY
MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS
7000 SW 62 Avenue* PH B * South Miami, Fl. 33143
Tel: (305) 274-5170* Fax: (305) 274-5172

PATIENT INFORMATION

Name: ____

Date of Birth: ___/___/_______ Last 4 of Social Security: __________

Purpose of Payment: ____

CARDHOLDER INFORMATION

Name:____

Billing Street Address:______________________________________

____

City:________________________ State:____________ Postal Code:______________________

Country:_____________________________ Email _______________________________

Direct Telephone: (______)_______-___________

Relationship to Patient: _____________________________________

BILLING INFORMATION

- ☐ I ____________________________________, hereby authorize **ROTEMBERG PLASTIC SURGERY** to use this credit card for the following amount $______________
- ☐ I ____________________________________, hereby authorize **ROTEMBERG PLASTIC SURGERY** to use this card to be used for the future deposits and or final payment.

CREDIT CARD INFORMATION

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover Card

Number:____

Expiration Month:______ Expiration Year:________ Security Code:______________

Cardholder Signature X______________________________ Date __/__/____