ROXBURY
SURGERY CENTER

450 NORTH ROXBURY DRIVE
SUITE 520
BEVERLY HILLS, CA 90210
P: (310) 246-4628
F: (310) 746-4663

AUTHORIZATION TO CHARGE CREDIT CARD ACCOUNT

PATIENTS NAME: _____

CARDHOLDER'S NAME: _____

BILLING ADDRESS OF CARD:

Street _____

City _____

State _____

Zip Code _____

CARDHOLDER'S PHONE: _____

TYPE OF CREDIT CARD:

❑ AMEX ❑ VISA ❑ MASTERCARD

ACCOUNT NUMBER: _____

ACCOUNT SECURITY CODE: _____ EXPIRATION DATE: _____

PAYMENT AMOUNT: _____

I AGREE TO PAY THE ABOVE AMOUNT FOR SERVICES RENDERED

SIGNATURE: _____ DATE: _____

IF YOU CHOOSE TO PAY YOUR FEES BY CREDIT CARD PLEASE COMPLETE THIS FORM AND EMAIL IT TO rscscheduling@roxburysurgerycenter.com OR FAX IT TO 310-746-4663.