GARY MOTYKIE M.D.
Plastic & Reconstructive Surgery
9201 SUNSET BLVD., STE GF-1
WEST HOLLYWOOD, CALIFORNIA 90069
PHONE: 310.246.2355 FAX: 310.246.2365

Credit Card Authorization

*** **Please also send a copy of your driver's license and credit card.** ***

Date: ____/____/_____

Name of Patient: _____

Date of Surgery: _____

Credit Card Number: _____-_____-_____-_____
(**If sending via email**: place last four numbers on a separate authorization form please read below)

Expiration Date: ___/___/_____

If using Care Credit, please circle payment term: 12 mos 24 mos 36 mos 48 mos 60 mos
(0% ARP for 12 months, 14.9% APR for the extended payment options)

Amount to be Charged: $_____
(Deposit to hold a surgery date: $1,000.00. – Full balance is due 2 weeks prior to surgery.)

Credit Card Billing Address: _____

_____

Security Number: _____
(Last 3 numbers on back of card and if using Amex: four numbers, top right on the front)

Name of Card Holder: _____

Card Holder's Phone Number: (_____) _____ - _____

I understand that Dr. Gary Motykie's office will charge my card for the amount (above), I also understand I will be sending the last four numbers of my credit card separately.

Signature: _____

Name (Printed): _____

VIA EMAIL: jade@drmotykie.com
If sending it by email, please DO NOT type/write last four numbers of the credit card on this sheet, please email them on a separate credit card authorization form, subject line: CCP2

VIA FAX:
Attn: Jade
Fax: 310-246-2365