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: _____-_____-_____-_____

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 (non-refundable): $1,000.00
- Full balance is due 2 weeks prior to surgery

Credit Card Billing Address: _____

_____

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

Name of Card Holder: _____

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

I authorize Dr. Gary Motykie's office to charge my card for the above amount.
I understand that there will be a non-refundable fee for booking and scheduling my surgery of $1,000.00, which is a part of the overall surgical fee.
Should I cancel my surgery without an approved medically acceptable reason, submitted in writing and acceptable to the practice, within 2 weeks of the scheduled surgery, this fee is forfeited. While this may appear to be a charge for services which were not provided, this fee is necessary to reserve time in the OR and in the practice, which are done when I schedule.

Signature: _____

Name (Printed): _____

VIA EMAIL: sandi@drmotykie.com

VIA FAX: Attn: **Sandi Fischer**
Fax: 310-246-2365