CREDIT CARD DEPOSIT / PAYMENT FOR ANESTHESIA

PLEASE EMAIL WHEN APPOINTMENT IS MADE OR FAX TO: 888-837-4248

PATIENT NAME:_____ DOB: _____

DOCTOR'S OFFICE:_____ Please circle the type of card:

- o VISA o MASTERCARD
- o AMERICAN EXPRESS o DISCOVER
- o CARE CREDIT

DATE of Surgery/Procedure:_____

Credit Card #_____

EXP DATE_____ SECURITY CODE (on back of card) _____

BILLING ADDRESS_____

AMOUNT:

- o DEPOSIT - $750.00 (applied to balance)
- o FULL AMOUNT (determined on the date of surgery at $200 for each 15 minutes.) Deposit is due on date of scheduling. Full amount is due on the treatment date. I authorize Joy Anesthesia to charge the above referenced card for the amount indicated. Any additional balance due after the procedure may be charged as indicated unless other arrangements have been made.

Signature _____

Joy Anesthesia
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Phone: 972-596-0746 Fax: 888-837-4248
Email: mail@joyanesthesia.com www.joyanesthesia.com