LASERCARE EYE CENTER

Date:_____
Faxed to:_____
Fax number:_____

I hereby authorize LaserCare Eye Center to bill my credit card for services that were rendered. I am not able to be there in person to sign the receipt, but I do realize that a receipt will be mailed to my home address. I realize that they will not bill my credit card account for the amount owed until I send in this statement of verification.

Name of the Card Holder:_____

Signature of the Card Holder:_____

The amount to be billed is:_____ and I verify that this is the agreed amount.

The Credit Card Account # is:_____ Expiration Date: _____

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

*After you have completed this authorization form, please fax it back to us at (214) 574-9601. You have 48 hours to return this completed form or your request for paying by phone will be denied.