San Luis Dermatology & Laser Clinic, Inc.

15 Santa Rosa Street – San Luis Obispo, CA 93405
1551 Bishop Street, Suite 410 – San Luis Obispo, CA 93401

Authorization to charge services to credit card

This agreement is required if you wish to charge your credit card for services provided to:

_____ Account #: _____
Name of Patient

☐ **Keep Credit Card on file for all services.** **Specific Date(s) of Service:** _____

☐ **No Receipt needed**

☐ **Please mail a receipt for payment to my address on file.**

☐**Visa®** ☐**MasterCard®** ☐ **Discover® Credit Card #**_____**Exp:**_____
MM/YY

Cardholder Name:_____

_____ _____
Signature **Date**