



# Hogan Health Care, P.C. Hogan Advanced Liposuction Center

Body Sculpturing & Teaching Center  
610 Peachtree Pkwy. Suite 203  
Cumming GA 30041

Dear Patient,

Please take a moment to read this form carefully. Your completion of this authorization form helps us to protect you from credit card fraud. All information entered on this form will be kept strictly confidential.

## Credit Card Authorization

### Why we use it?

We have taken an extra step to protect our patients as well as ourselves from credit card fraud. An authorization form, filled out by you and faxed to us along with a copy of your credit card (front and back) and drivers' license ensures us that the person using your card is you.

This is to confirm that you are purchasing our services by using your credit card. It is very important for us to have you complete this form and fax it back to us as soon as possible, so we can process your payment here at Hogan Healthcare Center Inc.. Thank you for your business.

Cardholder: \_\_\_\_\_ Credit Card #: \_\_\_\_\_

Visa      MasterCard      American Express      Discover      ATM/Debit

Expiration Date: \_\_\_\_\_ 3-Digit security code on back of card \_\_\_\_\_

Home or Credit Card's Billing Address:      4-Digit Security Code in Front of AmEx \_\_\_\_\_ (AmEx only)

\_\_\_\_\_  
\_\_\_\_\_

I understand that an additional charge of 2.1% of the total cost is added for the use of a Visa Card. I understand that an additional charge of 3.1% of the total cost is added for the use of American Express.

I hereby authorize Hogan Healthcare Center, Inc. to charge the purchase amount \$ \_\_\_\_\_ to my credit card.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**\*\*Please attach a copy of Picture Identification Card and front of credit card to be used\*\***