ART QUINTANILLA, MD
BOARD CERTIFIED
PHYSICIAN

DESERT MEDICAL REJUVENATION
35900 BOB HOPE DRIVE SUITE 130
RANCHO MIRAGE, CA 92270
PHONE: (760) 832-7279

CREDIT CARD AUTHORIZATION FORM

I ____ authorize Desert Medical Rejuvenation to charge my credit card indicated below for payment up to $2,000.00.

Phone #: (______)______________________ Email: ____

Billing Address: ____

City, State, Zip: ____

Account Type: ❑Visa ❑MasterCard ❑Amex ❑Discover

Cardholder Name: ____

Account Number: ____

Expiration Date: __________________

CVV (3-digit number on back of Visa/MC, 4 digits on front of AMEX): ___________

Postal Zip Code: _________________

_____________________________________ ________________________________

Representative Signature Date

Phone authorizations will be considered as signed in absentia. I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlines above. I understand that this authorization will remain in effect until the designated expiration date or until I cancel it in writing. If the above noted payment dates fall on a weekend or holiday. I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. I clarify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

DESERT MEDICAL
REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE