Thank you for your interest in the Cosmetic Surgery Center of Maryland. Our goal is to provide you with the information that you need as you consider plastic surgery. We want you to feel comfortable with our staff and hope you will contact us when you have any questions. Please fax the form back with a copy of the credit card and driver's license to 410.505.1930.

Thank you in advance and we look forward to seeing you again soon.

ATTN: Billing Department

I, ____, authorize The Cosmetic Surgery Center of Maryland to charge my credit card a $____________payment to be used for medical services.

We also need a photo copy of your driver's license and credit card.

Please circle one: MC Visa American Express

Credit card Number ______________________________________ Ex. Date:_________
Cardholder Billing Address: ____
City, State, Zip Code:____
V Code: ________________

Cardholder Signature: ____

*** If for any reason you cancel your surgery after the payment date, one half of the surgeons fee as well as any fees for implants and/or garments will be returned to the patient. If the patient reschedules surgery, all monies will be applied to the new surgery date. For each surgical date cancelled, after the first time we have rescheduled your original date, an administrative fee of $500.00 will be collected in order to reschedule your surgery.***