NON- REFUNDABLE DEPOSIT CREDIT CARD AUTHORIZATION

**** THE DEPOSIT WILL GO TOWARD SURGEON'S FEE**

I, _____, hereby authorize William P. Adams, Jr., MD PA to charge my account up to **$500.00** for services rendered in connection with my surgical consultation performed by William P. Adams, Jr., M.D. which may include charges from Park Cities Surgery Center, Lemmon Ave. Surgery Center and North Star Anesthesia. Any amount in excess of this will require additional authorization.

Signature:	
Name as it appears on the card:	
Credit Card Type:	
Account Number:	
Expiration Date:	
3 Digit Security Code	
Amount to be Charged:	500.00

Complete the following portion if a second credit card is being used.

Signature:	
Name as it appears on the card:	
Credit Card Type:	
Account Number:	
Expiration Date:	
3 Digit Security Code	
Amount to be Charged:	

Please fax to 214-965-9180