MATTHEW SCHULMAN M.D.

BOARD CERTIFIED PLASTIC SURGEON

950 Park Avenue
New York, NY 10028
212-289-1851

AUTHORIZATION TO CHARGE CREDIT CARD

Please charge my credit card and number listed below:

Visa_____ MasterCard_____ Discover_____

Account Number: _____ Exp. _____ Sec Code_____

First and Last Name:_____
(As it appears on the credit card)

Billing Statement Address:_____

_____

Tel#: Home:_____/Cell#:_____

I, _____, authorize Matthew Schulman, M.D.,P.C.

to charge my credit card for $_____. This authorization, once signed,

is valid whether or not a charge slip has been signed.

Signature_____ Date_____