



**Wellesley  
Cosmetic  
Surgery**

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## Charge Agreement

I, \_\_\_\_\_ hereby authorize Wellesley Cosmetic Surgery to charge my credit card,

Type:  Visa  Mastercard  American Express  Discover

Name on Card \_\_\_\_\_ Card Number \_\_\_\_\_

Security Code (Three-digit number found on the back of card for Visa/MC/Discover, on front for Amex) \_\_\_\_\_

Expiration Date \_\_\_\_\_

In the amount of \$ \_\_\_\_\_

I understand that this charge will be used in payment of a surgical procedure to be performed on

(patient name) \_\_\_\_\_, by Dr Arthur Shektman

on (date) \_\_\_\_\_

I further understand that by signing this agreement I express my acceptance of this charge and therefore will not be able to cancel this charge.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Cardholder Signature \_\_\_\_\_

Please fax this form to (781) 239-0681 or mail it to the practice.

Certified by the American  
Board of Plastic Surgery

Facility accredited by the Joint  
Commission on Accreditation  
of Healthcare Organizations

There is a \$75 consultation fee. Your appointment needs to be secured with a valid credit card. In case of a no show, your card will be charged a full consultation fee. If you cancel your appointment ahead of time, your card will not be charged.