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## APPOINTMENT REQUEST DEPOSIT FORM

Patient:
Cardholder's Name:
Credit Card: (Please check): Visa MasterCard American Express Discover
Card Number:
Billing Address:
Expiration Date:
V-Code on back of card:
By signing below, I authorize Dr. Pilest to charge this credit card a deposit for the following amount: \$
This amount is only refunded if given a <b>48 hour notice</b> for cancelled or rescheduled appointments.
Cardholder's Signature:Date:

**Please fax to 949-727-3888** or Scan and email to <a href="Mariah@totaldermatology.com">Mariah@totaldermatology.com</a> Thank you very much!

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