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Nissan Pilest, M.D.
*Board Certified by the
American Board of Dermatology*

SATURDAY APPOINTMENT REQUEST FORM

Patient: _____
Appointment date requested: _____
Appointment time requested: _____
Procedure: _____

Cardholder's Name: _____
Credit Card: (Please circle): Visa MasterCard American Express Discover
Card Number: _____
Expiration Date: _____
V-Code on back of card: _____
Billing Address: _____

By signing below, I authorize Dr. Pilest to charge this credit card a deposit for the **FULL amount** of the procedure. (Amount noted at your consultation)

This deposit is **ONLY** refundable when given a 72 hours advanced notice, for a cancelled or rescheduled appointment. Amount: \$ _____

Once we receive this completed form we will check if the requested date and time are available and call to confirm and/or modify the appointment.

Please note that Saturday's schedule is subject to change, however, we will notify you of any deviation within 72 hours of the appointment.

Cardholder's Signature: _____ Date: _____

Please fax back to 949-727-3888.

Thank you very much!

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