



Credit Card Authorization Form (Canadian Cards only)

Date: _____

Patient Name: _____
First name Last name

Name of Cardholder (as on card): _____

Billing Address: _____
Address line 1

_____ Address line 2

_____ City Province Postal code

Telephone #: _____

Email address: _____

Visa MasterCard Amex Canada

Credit card number: _____ - _____ - _____ - _____

Expiration Date: / / / / /
Y Y Y Y M M

CSC number: _____

(Found on the back of Visa and MasterCard (3 digits), and on the front of Amex (4 digits))

Customer Service phone number from the back of the credit card: _____

Product to be purchased (select *one* order option):

Prenatal Test	21, 18, 13	All chromosomes	Microdeletions	\$ (CAN)	Order
Verifi	•			550.00	<input type="checkbox"/>
	•	•		620.00	<input type="checkbox"/>
Verifi Plus	•		•	700.00	<input type="checkbox"/>
	•	•	•	770.00	<input type="checkbox"/>

I hereby authorize Mount Sinai Services Inc. to charge my Credit Card for the amount listed above. I certify that I am the authorized Card holder of record and that I have full authority to make purchases on behalf of the account listed above. I understand that Mount Sinai Services Inc. may contact me directly if there will be any issue with the payment.

Printed name: _____

Signature of Card holder: _____