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	□
	●	●		620.00	□
Verifi Plus	●		●	700.00	□
	●	●	●	770.00	□

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: _____

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