

CREDIT CARD PAYMENT AUTHORIZATION

Patient Surname

Patient First Name

Card Number

CVC-3 digit code

Expiry (MM/YY)

Type

MC

Visa

I authorize the Pacific Centre for Reproductive Medicine (PCRM) to charge my credit card for payment of services and/or medications rendered. If PCRM is unable to process payment I will be responsible for an alternate payment arrangement.

By signing this authorization I acknowledge that I have read and agree to all of the above information and warrant all information is true.

Name as appears on Card

Signature of Card Holder

Date: _____