PFC CREDIT CARD AUTHORIZATION

Please complete this form and fax it back to ***Pacific Fertility Center*** ***415-834-2509***

ATTENTION: ________________________________

CARDHOLDER'S INFORMATION:

VISA *MASTERCARD* *AMERICAN EXPRESS* *DISCOVER CARD*

CARDHOLDER'S NAME: ____________________, ______________________________
Last *First*

DRIVER'S LICENSE/ID: #____________________________ **EXPIRES:**__________

CARDHOLDER'S BILLING ADDRESS: ______________________________________
Address

Telephone Number: ______________ ______________________________________
City *State* *Zip Code*

CREDIT CARD NUMBER: __________________________________ **EXPIRES:** _______
3 or 4 digit verification number next to Signature Line on the back of the card: ___ ___ ___ ___

AMOUNT TO BE CHARGED: $_____________________

I authorize Pacific Fertility Center to charge my credit card as listed above.

CARDHOLDER'S ***SIGNATURE:*** ___________________________ **Date:** ________________
__ Please sign and MAIL or FAX (415-834-2509) to PFC. A signed copy will be mailed to you

PATIENT'S NAME: ________________________, ____________________________
Last First

Patient's **Social Security Number:** ___ ___ ___ / ___ ___ / ___ ___ ___ __ *****REQUIRED*****

Account: #________________

- **Date of Service for which Credit Card is being charged:** ______________________
- **Cycle Payment for the month/year of :** ____________________________________
- **Donor/GC Screening Payment:** ____
- **Donor/GC Medication Payment:** ____
- **Annual Embryo Storage** __________ **Annual Sperm Storage**__________
- **Other:**____

FOR OFFICE USE ONLY:

CHARGE REQUEST RECEIVED BY: _________________ ***Date:*** ________________________
CREDIT CARD PROCESSED BY: ____
DATE PROCESSED: ________/________/________
Mailed PATIENT'S RECEIPT on: ________/________/________