Courtagen
DIAGNOSTICS LABORATORY

Authorization to Charge Credit or Debit Card

Patient Name: _____

Patient DOB: _____

Bill #: _____

Amount: $_____

Payment Method:

☐ MC / VISA ☐ Amex ☐ Discover

Name on Card: _____

Card #: _____

Billing Address: _____

Expiration (MM/YY): _____

CSV # (3 or 4 digit code): _____ (Front of Amex; Back of MC, Visa, Disc)

By signing below, I authorize Courtagen Diagnostics Laboratory to charge my Credit or Debit card for the amount indicated above.

Cardholder Signature: _____ Date: _____

Please review Courtagen's Privacy Policy at www.courtagen.com

Courtagen Diagnostics Laboratory
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