Laurel Fertility Care

Growing dreams together

Credit Card Authorization Form

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US.
All information will remain confidential.

Cardholder Name: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____AMEX

Credit Card Number: _____

Expiration Date: _____

Card Identification Number (last 3 digits) _____

Amount to Charge: **$ 40.00** (USD)

I authorize Laurel Fertility Care to charge the agreed amount listed above to my credit card provided. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.
I also understand that upon cancellation, I will be charged a fee of $40.00 if a **48 hour cancellation notice** is not provided prior to my appointment.

** We will only charge this amount if the 48 hour cancellation notice is not provided prior to any of your appointments **

Cardholder – Print Name, Sign and Date Below:

Print Name: _____

Dated: _____

Signature: _____