Dynacare®

Payment Authorization Form

PATIENT INFORMATION

Last Name: _____

First Name: _____

Date of birth: _____ (Year/Month/Day)

Referring physician: _____

Address: _____
No Street Apt.

_____
City Province Postal code

Tel (home): _____

Tel (daytime): _____

TEST INFORMATION

☒ **Color Hereditary Cancer Test**
30-gene test (including *BRCA1* and *BRCA2*) for hereditary cancer risk **$589**

PAYMENT

☐ VISA ☐ Certified cheque (No personal cheques accepted)

☐ MasterCard

☐ AMEX

Credit Card Number: __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __

Expiry date: _____ / _____ Security code: __ __ __
MM YY

Cardholder: _____ _____
Name Signature

Date: _____
(Year/Month/Day)

INTERNAL USE

Date: _____ Lab #: _____

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