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

☒ **Genecept Assay** **$495**

Includes: SLC6A4, CACNA1C, ANK3, 5HT2C, MC4R, DRD2, COMT, ADRA2A, MTHFR (A1298C/C677T), BDNF, OPRM1, GRIK1, CYP1A2, CYP2B6, CYP2C9, CYP2C19, CYP2D6, CYP3A4/5

PAYMENT

☐ VISA

☐ MasterCard

☐ AMEX

☐ Certified cheque (No personal cheques accepted)

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

Expiry date: ________ / ________
MM YY

Security code: __ __ __

Cardholder: ______________________ ______________________
Name Signature

Date: ______________________
(Year/Month/Day)

INTERNAL USE

Date: ______________________

Lab #: ______________________

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