OmniSeq Payment Authorization Form

Dynacare® | OmniSeq®

Patient Information

Last Name: _____

First Name: _____

Date of Birth: _____ (YYYY/MM/DD)

Referring Physician: _____

Address: _____ (No. / Street / Apt.)

_____ (City / Province / Postal Code)

Tel. (home): _____

Tel. (daytime): _____

Referring Physician: _____

Test Information

OmniSeq®

◯ OmniSeq INSIGHT℠ *$4825*

Payment

☐ VISA ☐ AMEX (No personal cheques accepted)

☐ MasterCard ☐ Certified cheque

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

Expiry date: _____ (MM) / _____ (YY) Security Code: _____ (3 digits)

Cardholder: _____ (Name) _____ (Signature)

Date: _____ (YYYY/MM/DD)

INTERNAL USE

Date: _____ Lab#: _____