Dynacare®

# Genetic Testing Payment Authorization Form

## Patient Information

Last Name: ______________________________

First Name: ______________________________

Date of Birth: ______________________________
Date (YYYYMMDD)

Referring Physician: ______________________

Address: ______________________________
No. Street Apt

______________________________
City. Province Postal Code

Tel (home): ______________________________

Tel (daytime): ____________________________

## Test Information

Genetic Tests

| Test Code | Test Name | Price |
|---|---|---|
| | | |
| | | |
| | | |

## Payment

☐ VISA

☐ MasterCard

☐ AMEX

☐ Certified cheque

(No personal cheques accepted)

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

Expiry date: _____ / ______
MM YY

Security Code: _______
(3 digits)

Cardholder: ______________________________ ______________________________
Name Signature

Date: ______________________________
(Year/Month/Day)

INTERNAL USE

Date: ______________________________

Lab#: ______________________________

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