NATIONAL labs

Credit Card Authorization Form for Laboratory Payment

All fields must be printed legibly and completed fully.
If a copy is needed for your records, please ask the office to provide a photocopy of the completed form.

Clinic-Patient Information
Clinic Name: _____
Patient Name: _____ Date of Birth: _____
Amount Paid: $_____ Bill/Account# (if avail.): _____
Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ Cardholder Zipcode: _____

I, _____ (print name), authorize National Labs to charge my credit card for the indicated amount. This is in accordance with health care insurance and medical billing policy & procedures as I am held responsible for this amount.

_____ _____
Paying Party Signature Date