



Laurel Fertility Care

Growing dreams together

## Credit Card Authorization Form

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US.  
All information will remain confidential.

Cardholder Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
\_\_\_\_\_

Credit Card Type:  Visa  Mastercard  Discover  AMEX

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Card Identification Number (last 3 digits) \_\_\_\_\_

Amount to Charge: **\$ 40.00** (USD)

I authorize Laurel Fertility Care to charge the agreed amount listed above to my credit card provided. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

I also understand that upon cancellation, I will be charged a fee of \$40.00 if a **48 hour cancellation notice** is not provided prior to my appointment.

**\*\* We will only charge this amount if the 48 hour cancellation notice is not provided prior to any of your appointments \*\***

Cardholder – Print Name, Sign and Date Below:

Print Name: \_\_\_\_\_

Dated: \_\_\_\_\_

Signature: \_\_\_\_\_