PCRM
PACIFIC CENTRE FOR REPRODUCTIVE MEDICINE INC.

## CREDIT CARD PAYMENT AUTHORIZATION

**Patient Surname** **Patient First Name**

Card Number CVC-3 digit code Expiry (MM/YY) Type

☐ MC ☐ Visa

I authorize the Pacific Centre for Reproductive Medicine (PCRM) to charge my credit card for payment of services and/or medications rendered. If PCRM is unable to process payment I will be responsible for an alternate payment arrangement.

By signing this authorization I acknowledge that I have read and agree to all of the above information and warrant all information is true.

Name as appears on Card **Signature of Card Holder**

Date: _____



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