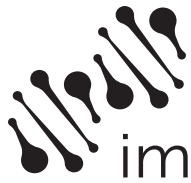


PLEASE DO NOT SEND FORM WITH SAMPLE;

Send this form to Impact Genetics

BY FAX TO 905-697-9786

For patient pay, testing will be held pending receipt of this completed form.



impact genetics

Form 1d: Credit Card Authorization for Non-Covered Services

To be completed by and returned to Impact Genetics *directly by the cardholder*.

Billing Information

Laboratory Test:

Retinoblastoma Genetic Test

HHT Genetic Test

Uveal Melanoma Prognostic Genetic Test

Uveal Melanoma 5 Gene Panel (*SF3B1, EIF1AX, GNAQ, GNA11, BAP1*)

BAP1-TPDS (*BAP1 Tumor Predisposition Syndrome*) Genetic Test

Patient name: _____ Date of birth: Y _____ M _____ D _____

VISA MASTERCARD

Name on card: _____

Billing address: _____

City: _____

Province/State: _____ Postal/Zip code: _____

Country: _____

Card #: _____ Expiration date: _____

Contact Information

Impact Genetics will contact the cardholder prior to placing the credit card charge, to confirm the date and amount of the charge. Please **provide at least 2 contact methods** and check preferred:

Phone: _____

Email: _____

Fax: _____

Statement of Financial Responsibility U.S. PATIENTS ONLY

Box below must be checked for testing to proceed.

I understand that my insurance plan is not expected to pay for these test(s) at 100% and I agree to be personally and fully responsible for payment.

Cardholder's signature: _____ Date: _____