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: _____