Please do not send form with sample:
Send this form to Impact Genetics
by fax to 905.697.9786
or call 647.478.4902/1.877.624.9769
For patient pay, testing will be held pending receipt of this completed form.

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

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

Laboratory Test

☐ **Retinoblastoma Genetic Test**
☐ **Uveal Melanoma Prognostic Genetic Test**
☐ **HHT Genetic Test**
☐ ***MLH1/MSH2/MSH6/PMS2/EPCAM* Somatic Tumour MMR Sequencing and Deletion/Duplication Test**

Billing Information

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: ______________________

CVC # (3-digit Card Verification Code on back of card): ______________________

Contact Information

Please provide at least 2 contact methods and check preferred:

☐ Phone: ______________________
☐ Email: ______________________
☐ Fax: ______________________

Statement of Financial Responsibility

Box below must be checked for testing to proceed.

☐ **I understand that my health coverage 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: ______________________