# Credit Card Authorization Form

Allele Diagnostics
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Completing this form authorizes Allele Diagnostics to place a hold on your credit card prior to initiating testing and to charge your credit card for the full amount due once testing is complete. Allele Diagnostics requests this form be completed and sent with the specimen for testing or faxed to 509-232-5779. If you have any questions, contact our laboratory at 844-255-3532 to discuss.

**All fields are required for specimen processing. Failure to complete this form may result in delay of testing.**

## Cardholder Information

Name: _____ Telephone: _____
Billing Address: _____
City: _____ State: _____ Zip Code: _____ Email: _____

## Credit Card Information

Card Number: _____ Expiration Month/Year: _____
Security Code (CVV): _____ Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

## Authorized Signature for Credit Card Payment

**Credit Card Holder:** By signing this form, I request and authorize Allele Diagnostics to charge the credit card listed above, and I acknowledge that I will be charged the prices marked below. I understand that I am opting to receive a discounted self-pay rate, and this testing will not be billed to my insurance company by the laboratory. I understand that a hold will be placed on my credit card for the total charge until all testing is complete.

**Signature:** _____ **Date:** _____
*Signature of Credit Card Holder*

| Ordered | Test Name | Self-Pay Discounted Price |
|---|---|---|
| ☐ | Prenatal Rapid Microarray | $1000.00 |
| ☐ | Maternal Cell Contamination Testing | $200.00 |
| ☐ | Prenatal Karyotype | $875.00 |
| ☐ | Rapid Microarray for Child or Parents | $900.00 |
| ☐ | Parental FISH | $425.00 |
| ☐ | Other testing (please call lab to discuss pricing) | Write in price(s) here |
| | Write in name of test(s) here | |


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