THE FOUNDATION FOR EMBRYONIC COMPETENCE
ADVANCING KNOWLEDGE. ENHANCING OUTCOMES.

CREDIT CARD AUTHORIZATION FORM

Completed forms may be faxed (908-580-1201), emailed (Billing@FEClabs.org), or mailed to the FEC at 140 Allen Road, Suite 300, Basking Ridge, NJ 07920

Payment will not be processed until samples are received by the FEC. Missing or incomplete payment will delay release of results by the FEC.

Patient Name: _____

Patient Address: _____

_____

Patient Phone #: _____

Name as it appears on card: _____

Billing Address (if different from above): _____

_____

Billing Phone # (if different from above): _____

Please send receipt to (check one or both): ☐ Patient ☐ Cardholder

Payment Information

Accepted payment Methods: AMERICAN EXPRESS, MasterCard, VISA, DISCOVER NETWORK

16 Digit Card Number: _____

Expiration Date (MM/YYYY): _____

3 Digit Security Code: _____ OR 4 Digit Amex Security Code: _____
(On the back of the card in signature box) (Last four digits on front of card above ID)

I, _____, hereby authorize FEC to charge the above credit card in the amount of $ _____. I understand that by signing below I am responsible for payment of the described charges in accordance with the terms of the issuing credit card company.

Signature: _____ Date: _____
(Authorized Credit Card Holder)

Signature: _____ Date: _____
(Patient)