

CREDIT CARD AUTHORIZATION FORM

Unless otherwise indicated on the test requisition submitted from my office I
hereby authorize SpectraCell Laboratories, Inc. to charge my credit card for all current and future requisition testing submitted from my office.

Provider's Account #

Address Associated With Your Credit Card

Street:

City:

State:

Zip:

Phone:

Fax:

Please indicate the email address you would like receipts to be sent.

Email:

List office name or any other doctors authorized to submit charges to the credit card:

Credit Card Type: Visa

MasterCard

American Express

Discover

Name as it appears on the credit card:

Credit Card Number:

EXP Date:

SEC Code:

Authorization Signature:

By entering your name, you electronically authorize SpectraCell Laboratories, Inc. to charge your credit card.

Email completed form to forms@spectracell.com

For SpectraCell Laboratories Office Use Only:

Recurring # _____

Entered by: _____

Received: _____

Comments: _____