

Payment Consent Form

Name _____
Print Name as it appears on your card

Name of client if different _____

I authorize *Quest Diagnostics, Inc. and PayPal*, to charge my credit card for:

- Initial*
- _____ This visit only, for the amount of \$ _____
- _____ All fees in the next 12 months, beginning ____ / ____ / ____
- _____ To charge my card for the balance of fees not paid by my insurance company
- _____ I understand the 48 hour cancellation policy and authorize missed appointment fees to be charged to my credit card (required).

Type of Card: Visa MasterCard

Expiration Date _____

Credit Card Number _____ - _____ - _____ - _____ CVV Number _____
A 3-digit number in reverse italics on the **back** of the credit card

Card Holder's Billing Address for Credit Card Statements:

Street *City* *State* *Zip*

Email: _____ Phone: _____

Card Holder Signature _____ Date ____ / ____ / ____

The date listed on your credit card statement may be different than the actual date of service.

Credit card transactions will appear on your bill as PAYPAL *KRISTENWYNNS.

A receipt for your payment will be emailed to you from PayPal. Thank you.