Wisconsin Fertility Institute

CREDIT CARD AUTHORIZATION FORM

Please complete the following credit authorization. Any patient balance left unpaid 30 days after billing will be charged to your credit card on file. If you are responsible for paying for a partner, donor or surrogate, these charges will be assessed to your card prior to or at the time of their service.

CREDIT CARD BILLING INFORMATION	
Patient Name	
Additional Patient Name	
Additional Patient Name	
Credit Card Type	○ Visa ○ Master Card ○ Discover
Name Appearing on Card	
Credit Card Number	
Security Code	last 3 digits from the back of the card
Expiration Date	
Billing Address	
City	
State	
Zip Code	
Phone #	
Email address	

Mail Receipt to	
City	
Zip Code	

I hereby authorize Wisconsin Fertility Institute's financial representatives to charge my credit card for balances due on my account and/or the account of the patient(s) identified above.

Signature_____ Printed Name_____ Date_____