



CLIA certified: 43D0975076

425 8<sup>th</sup> Street South, Brookings, SD 57006

## CREDIT CARD AUTHORIZATION

Date \_\_\_\_\_

### PATIENT INFORMATION

Physician /Clinic \_\_\_\_\_

Patient Name \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

### CREDIT CARD INFORMATION

Check one:  Discover  Mastercard  Visa

Card Holder's Name \_\_\_\_\_

Card Holder's Billing Address \_\_\_\_\_

Credit Card Number \_\_\_\_\_ Security Code \_\_\_\_\_

(3 digit number found on back of card)

Expiration Date \_\_\_\_\_

**Amount      \$450.00**

Card Holder's Signature \_\_\_\_\_

**PLEASE EMAIL THIS FORM TO [ORDERS@SCSATEST.COM](mailto:ORDERS@SCSATEST.COM) - DON'T SEND WITH TANK**

PH 605-592-9071 TF 866-219-1338

WEB [scsatest.com](http://scsatest.com) EML [Jen@scsatest.com](mailto:Jen@scsatest.com)