CLIA certified: 43D0975076

302 6TH Street West, Suite B, 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 FAX THIS FORM TO 605-592-9021 – DO NOT SEND WITH TANK.

PH 605-592-9071 TF 866-219-1338 FX 605-592-9021 WEB scsatest.com EML Jen@scsatest.com