Acacio Fertility Center, Inc.

Credit Card Authorization Form **AFC BILLING ACCT#:_____**

Please complete and fax to: (949) 249-9203 **PATIENT NAME:_____**

SERVICE: _____

I/We _____authorize Acacio Fertility Center, Inc. to charge my card:

( ) Mastercard ( ) Visa ( ) American Express or ( ) Discover

Credit card # _____ expires_____

in the amount of $_____, as payment for medical services (contracts for cycle plan signed

under separate agreement). My billing address is as follows:

_____

SECURITY CODE: _____ (3 DIGIT FOUND ON BACK OF VISA/MC/DISCOVER OR 4 DIGIT ON FRONT OF AMEX)

Signed:_____

Date:_____