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Therapeutics & Diagnostics

9410 CARROLL PARK DRIVE
SAN DIEGO, CA 92121-5201
TOLL FREE: (888) 423-5227
FAX: 858 535-2191

CREDIT CARD AUTHORIZATION FORM

PLEASE PRINT

PATIENT NAME:____DOB:______/_______/________

TEST(S) ORDERED:____________________,______________________,______________________

CARD HOLDER NAME:____

ADDRESS:____

CITY:______________________STATE:______________ZIP:___________COUNTRY:___________

PHONE NUMBER: (______)___________________(HOME), (______)___________________(WORK)

EMAIL ADDRESS:____

( ) MASTERCARD EXP. DATE________/_________3-DIGIT SECURITY CODE:____________
( ) VISA

ACCOUNT #__________________-_________________-_________________-________________

RECEIPT REQUESTED **YES** **NO** INSURANCE CLAIM FORM (**HCFA 1500**) REQUESTED **YES** **NO**

BY SIGNING, THE CARD HOLDER AGREES TO ACCEPT CHARGES BILLED TO THE ABOVE CREDIT CARD FOR THE ABOVE LISTED OR ATTACHED LABORATORY SERVICES. PLEASE REFER TO PROMETHEUS' NOTIFICATION OF PATIENT FINANCIAL RESPONSIBILITY FOR CURRENT PRICING.

X____

(SIGNATURE REQUIRED FOR PROCESSING)

FOR PROMETHEUS USE ONLY

PATIENT ID: ____________ AMOUNT: $____________ PROCESSING DATE:_____/______/_______

AUTHORIZATION #:_________________________TRANSACTION #:__________________________

TICKET/ INVOICE #:________________,________________,_______________,_______________

NOTES:____INITIALS:______

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