City Fertility
Global CHA IVF Partners

Patient Code:
(Office Use Only)

CREDIT CARD AUTHORISATION

To be completed by Patient/Partner:			
Patient Surname		**Partner Surname** (if applicable)	
First Name		**First Name**	
Date of Birth	/ /	**Date of Birth**	/ /
Mobile No.		**Mobile No.**	
Address			

I/we authorize City Fertility to charge the nominated credit card below for _____ procedure.

I/we understand that the nominated card below will be charged on the day of the procedure once the laboratory has confirmed that all testing has been completed.

I/we understand that it is my/our responsibility to ensure that the card provided has the correct credit limit and daily limit available for this transaction to be processed. Should the transaction be declined, this may result in the cancellation of the cycle or results being withheld.

I/we understand that if the invoice exceeds payment terms and multiple attempts have been made to contact me/us then the invoice may be forwarded to a debt collector for collection of the outstanding fees.

I/we agree that any dispute about fees debited to the card below needs to be made in writing to City Fertility.

I/We understand that City Fertility will securely destroy this form once payment has been made and will not retain these details on file

CREDIT CARD TYPE MasterCard ☐ Visa Card ☐

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry: ☐☐☐☐ Card Verification No: ☐☐☐

Name on Card:			
Card Holder Signature:		Date:	/ /

City Fertility will send a receipt for fees once the payment has been processed. City Fertility agrees to keep the above credit card details confidential and will not use them for any other purpose other than to process fees as per your instruction above.