Dynacare®

Payment Authorization Form

PATIENT INFORMATION

Last Name: _____

First Name: _____

Date of birth: _____ (Year/Month/Day)

Referring physician: _____

Address: _____
No Street Apt.

_____
City Province Postal code

Tel (primary): _____

Tel (secondary): _____

TEST INFORMATION

☐ Harmony Prenatal Test $299

☐ Harmony Prenatal Test + 22q11.2 Option $299

PAYMENT

☐ VISA ☐ Certified cheque (No personal cheques accepted)

☐ MasterCard

☐ AMEX

Credit Card Number: __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __

Expiry date: _____ / _____ Security code: __ __ __
MM YY

Cardholder: _____ _____
Name Signature

Date: _____
(Year/Month/Day)

INTERNAL USE

Date: _____ Lab #: _____

3885, boul. Industriel, Laval (QC) H7L 4S3 T 888.988.1888 F 450.663.4428 DynacareGenetics@dynacare.ca