PA ____ PBD ____

Hospital Physician

Memorial Sloan-Kettering Cancer Center

On Site Services - Credit Card Payment Authorization

Telephone: 212.639.4900 **Fax: 212.639.4939**

By signing below, I hereby authorize the Memorial Sloan-Kettering Cancer Center to charge my Credit Card for any physician visits, procedures, and tests, treatment modalities and/or services that may be provided at Memorial Sloan-Kettering Cancer Center.
For your protection, Credit Card Information (your Account Number/Signature) is not kept on file at the International Center. Therefore, we will request your signatory approval for each charge to your credit card.

Indicate type of credit card to be charged (We do not accept Debit Cards)

☐ American Express ☐ Mastercard ☐ Visa ☐ Diners Club ☐ Discover

Credit Card Number: ______________________________________ Expiration Date: ____/____/____

Name (as it appears on the credit card): ____________________________ Today's Date: ____/____/____

Signature of authorized cardholder: ____

Patient Name: _________________________________ Medical Record Number: ___________________

Comment: ____

Amount: $_________________.________

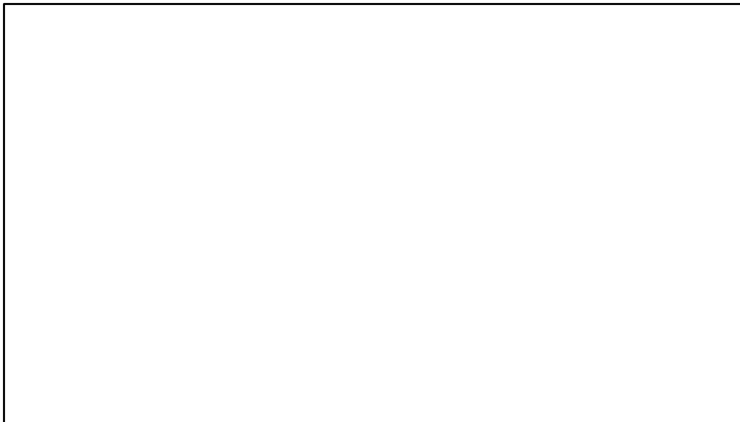
Cardholder's Business address: *(The Address where the credit card statements are mailed)*

Street: ____

City: ____ Country: ___________________________________

Postcode: ____

Credit Card Authorizations with your signature may be faxed to the Memorial Sloan-Kettering International Center at 212.639-4939



FOR YOUR OWN PROTECTION – DO NOT EMAIL CREDIT CARD INFORMATION