Memorial Sloan-Kettering Cancer Center
The Bobst International Center
160 East 53rd Street, 11th Floor
New York, NY 10022

Credit Card Payment Authorization

Office Facsimile
(212)639-4938

Office Telephone
212-639-4900

By signing below, I hereby authorize the Memorial Sloan-Kettering to charge my Credit Card for any physician visits, procedures, and tests, treatment modalities and/or services that may be provided to me at Memorial Sloan-Kettering Cancer Center.

We will require approval for each charge to the credit card.

Patient Account Number_____

Patient Name (Last, First)_____

Payer Zip Code_____

Payer E-Mail_____

Relationship to Patient_____

Payment Amount_____

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

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

Credit Card Number_____

Exp. Date_____ CVN_____

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

Name_____

Signature_____

Street_____

City_____Country_____

PostalCode_____

Telephone # _____ Date_____

Credit Card Authorization may be faxed to
The Bobst International Center at **(212)639-4938**