



Rocky Mountain Analytical CREDIT CARD AUTHORIZATION

Use this form only if paying by Credit Card (Provider or Patient)

Please complete this form and FAX to 866.370.5223 or 403.241.4516

To avoid processing delays, please print all information clearly.

Provider or Patient Please check appropriate box:	Provider: <input type="checkbox"/>	Patient: <input type="checkbox"/>	
Last Name:		First Name:	
Clinic / Pharmacy Name: (Providers Only)			
Billing Address:			
City:		Province:	Postal Code:
Phone: ()		FAX: ()	
Email Address:			
Type of Credit Card:	Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Note: A receipt will be mailed.		
Amount Charged: \$ _____	PROVIDERS ONLY: please check appropriate box: Charge CREDIT CARD ONE TIME ONLY <input type="checkbox"/> OR keep CREDIT CARD ON FILE & charge automatically <input type="checkbox"/>		
Credit Card Number:		Expiry Date:	
Name on Credit Card if different from above:			

IMPORTANT NOTE: for Providers using CLINIC CREDIT CARDS

- If you are authorizing Rocky Mountain Analytical to use a CLINIC CREDIT CARD, please list the names of all Providers who are authorized to use this card in the boxes below.
- It is your responsibility to notify us of all changes regarding the use of your credit card.

Provider Name:		Authorized to use card number listed above:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provider Name:		Authorized to use card number listed above:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provider Name:		Authorized to use card number listed above:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provider Name:		Authorized to use card number listed above:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provider Name:		Authorized to use card number listed above:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provider Name:		Authorized to use card number listed above:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provider Name:		Authorized to use card number listed above:	Yes <input type="checkbox"/> No <input type="checkbox"/>

I authorize Rocky Mountain Analytical to bill my credit card (personal or clinic) for the requested laboratory services. If for any reason my credit card is not accepted I understand that I am financially responsible to Rocky Mountain Analytical and that Rocky Mountain Analytical may bill me based on the full price for the laboratory work performed.

Date:		Signature of Card / Clinic Owner:	
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