

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
[REDACTED]

Office Telephone
[REDACTED]

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 35367668

Patient Name (Last, First) [REDACTED]

Payer Zip Code 10021

Payer [REDACTED]

Relationship to Patient friend

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 [REDACTED]

Exp. Date 05/16 CVN 9129

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

[REDACTED]
Signature _____

Street 9 E 71st St.

City New York, NY Country USA

Postal Code 10021

Telephone # [REDACTED] Date 12/28/12

Credit Card Authorization may be faxed to
The Bobst International Center at [REDACTED]
Please call [REDACTED] to say you have faxed this form.

Payment Authorization Form Credit Card (revised 11/9/10)