Indian Egg Donors

Division of DGA, Inc.

CREDIT CARD ACCEPTANCE

Please charge my ☐ VISA ☐ MasterCard ☐ American Express

Card Number: _____ Security Code: _____
(found above your name)

Authorized Signature: _____ Exp. Date _____
(required)

Print name: _____ Address: _____

City: _____ State: _____ ZIP: _____

This credit card is to be kept on file and used for only approved charges. Supplements, deductibles and any noncovered charges by the insurance company may be charged to this card once I am notified of the amount. Please note that the charges will appear as Patients Medical PC.

	DATE OF CHARGES	REASON FOR CHARGE	AMOUNT
1	_____	Initial Application Fee	$100.00
2	_____	Agency Fee	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____