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 [redacted]

Patient Name (Last, First) [redacted]

Payer Zip Code 10021

Payer E-Mail [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 [redacted] CVN [redacted]

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

Name [redacted]

Signature

Street 9 E 71st St.

City New York, NY Country USA

PostalCode 10021

Telephone # [redacted] Date 12/28/12

Credit Card Authorization may be faxed to
The Bobst International Center at **(212)639-4938**
Please call 212-639-4900 to say you have faxed this form.

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