Robert A. Kaufmann, M.D.
Fort Worth Fertility, PA
1800 Mistletoe Blvd.
Ft. Worth, TX 76104

Please complete this form and fax it back to Fort Worth Fertility at 817-348-8264
ATTENTION: _____

CARDHOLDER'S INFORMATION:

VISA   MASTERCARD   AMERICAN EXPRESS   DISCOVER CARD
CARDHOLDER'S NAME:

_____,_____
Last   *First*
DRIVER'S LICENSE/ID: #_____ **EXPIRES:**_____

CARDHOLDER'S BILLING ADDRESS:_____
                                                                Address
Telephone Number: _____   _____
                                                          City   *State*   *Zip Code*
CREDIT CARD NUMBER: _____**EXPIRES:**_____
3 or 4 digit verification number next to Signature Line on the back of the card: ___ ___ ___ ___

AMOUNT TO BE CHARGED if known. If not known then I agree to be charged fee
for service amount on the date of service. I can be given an estimate of charges before
services are rendered: $_____

I authorize Fort Worth Fertility to charge my credit card as listed above.

CARDHOLDER'S *SIGNATURE:* _____ **Date:** _____
 Please sign and MAIL or FAX (817-348-8145) to FWF. A signed copy will be mailed to you

PATIENT'S NAME: _____,_____
                                        Last   **First**
Patient's **Social Security Number:** ___ ___ ___ / ___ ___ / ___ ___ ___ ___
***REQUIRED**if not anonymous egg donation*

Account: #_____

- ❑ **Date of Service for which Credit Card is being charged: _____**
- ❑ **Cycle Payment for the month/year of : _____**
- ❑ **Donor/GC Screening Payment: _____**
- ❑ **Donor/GC Medication Payment: _____**
- ❑ **Other: _____**

FOR OFFICE USE ONLY:
CHARGE REQUEST RECEIVED BY: _____ Date: _____
CREDIT CARD PROCESSED BY: _____
DATE PROCESSED:_____/_____/_____
Mailed PATIENT'S RECEIPT on: _____/_____/_____