The Inner Circle, 159 Rivonia Road, Morningside, 2196 | P.O. Box 652837, Benmore, 2010
Tel: (011) 911 4700 or 0861 882522 | Fax: 0865100951
www.vitalab.com | info@vitalab.com

AUTHORISATION TO DEBIT - CREDIT CARD

DATE: _____

PATIENT DETAILS

PATIENT NAME AND SURNAME: _____

PATIENT FILE NO: _____

PATIENT CONTACT NUMBER: _____

CONTACT PERSON (if not patient): _____

CREDIT CARD DETAILS

☐ Visa ☐ Mastercard ☐ American Express ☐ Diners

NAME ON CREDIT CARD: _____

CREDIT CARD NUMBER: _____

EXPIRY DATE ON CREDIT CARD: _____

LAST 3 DIGITS ON BACK OF CREDIT CARD (CSV): _____

AMOUNT TO BE DEBITED: _____

PATIENT SIGNATURE _____

NB: This completed and signed form must be returned to accounts@vitalab.com