MGZ
Medical Genetics Center

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www.mgz-muenchen.com

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Credit Card Payment Form

Date: ___________

MGZ Invoice #: ______________________

By submitting this form, I certify that MGZ GbR is authorized to charge the credit card detailed below in the amount of € ________, for the requested genetic services.

Name of cardholder: ____

Card #: _______________________________________

Expiration date (month/year): ____/_____

Security code (back of card): _________

I would like a receipt for this transaction sent to me by e-mail (circle one): Yes No

E-mail address: ________________________

Signature: ____________________________

Please return this completed form to us by e-mail or by fax:

e-mail: inquiry@mgz-muenchen.com

fax: +49 89 30 90 886-707

If you have any questions regarding billing and payment, contact us at inquiry@mgz-muenchen.com and reference our invoice number.

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