Recurring Credit Card Authorization

The undersigned authorizes IVF New England to debit my Credit Card for future payments due to Cryopreservation Storage Fees.

The following conditions apply to the recurring payments program:

You may discontinue the recurring credit card payment plan by providing IVF New England with signed disposition form indicating your intention of discontinuing cryopreservation storage. Please be aware that Reproductive Science Center requires recurring Credit Card Payment for all Cryopreservation Storage.

> *According to the American Society of Reproductive Medicine (ASRM), a Fertility Center is not ethically required to store cryopreserved biomaterials indefinitely and may dispose of such biomaterials after a passage of time that reasonably suggests that the owners have abandoned them. ASRM indicates that cryopreserved biomaterials may be considered abandoned when five years have passed without contact from the owner, diligent efforts have been made to contact the owner at the last known address and no written instructions from the owner exists concerning disposition.*

Please complete the information below:

Patient Name:_____ **Chart Number:**_____

I _____ authorize IVF New England to charge my:
(Full Name)

Visa MasterCard Discover Card American Express
(Please circle one)

credit card for $85 on the 20th day of each month for payment of Cryopreservation Storage Fees.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card(s) indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing and provide a completed disposition form to the practice, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

For Internal Use: □ FS □ FD □ VD

Cryopreservation Storage Payment Authorization

Credit Card Information

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV (3 digit number on back of card) _____

IVF New England
One Forbes Rd
Lexington, MA 02421
781 674 1200

Amount of Recurring Charge: _____

Frequency:_____

Start Date: _____

Signature:_____

Date:_____