



GTG Lab Case #
(for internal use only)
MD.....
Received:.....

Payment Form – SCN1A Genetic Testing

Family Name		Given Name(s)	
Date of Birth (dd-mm-yyyy)		Contact Number	
Address			
Suburb	State	Postcode	

The full amount of the test fee is charged at the time of sample submission.

Refer to our website for terms and conditions: www.gtmedical.com.au

I wish to pay by credit card Bankcard MasterCard Visa

Card No: _____ Expiry Date ____ / ____

For security purposes - please turn your card over and write the **last three digits** of the number on the signature panel of your card _____

Name as it appears on the card _____

Please debit my card for the following tests: (Please tick where applicable).

Gene Sequencing & MLPA Analysis	Gene Sequencing Only	MLPA Analysis Only
<input type="checkbox"/> SCN1A \$1,999	<input type="checkbox"/> SCN1A \$1,799	<input type="checkbox"/> SCN1A \$399
<input type="checkbox"/> SCN1A Express* \$2,199	<input type="checkbox"/> SCN1A Express* \$2,099	<input type="checkbox"/> SCN1A Express* \$499
<input type="checkbox"/> Predictive Testing/Segregation Analysis SCN1A		\$349
<input type="checkbox"/> Predictive Testing/Segregation Analysis SCN1A Express*		\$499

Total Payment = \$ _____

Signature of card holder _____ Date _____

Or

I have enclosed my payment with this application Money Order Cheque

(All prices current as of 17th May 2010. All prices are in Australian dollars)

*Express 5-8 business day service is for all SCN1A gene tests (Please contact GTG for special test requirements)

Institutional Billing: The hospital laboratory or referring physician can be billed. Please attach a letter stating the name of the contact person, address to which bill should be submitted, phone and fax number, and information required on the invoice (e.g. order number)