



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

Payment Options for 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 the amount of \$AUD

Signature of card holder _____ Date _____

Or

I have enclosed my payment with this application Money Order Cheque

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)