



**Credit Card Payment Authorization**

I authorize payment for charges, that I have agreed to in writing, for services provided by New York Cryo as well as for subsequent storage periods as agreed to in the Specimen Storage Agreement and Consent , to be charged to my credit card. I understand that this authorization shall commence on the date hereof and shall continue until either party provides written notice (the depositor must have their notice to New York Cryo notarized) to the other of its intent not to renew this Authorization. If this authorization is for payment of storage of my semen specimens I understand that any written notice of non-renewal be received by New York Cryo at least thirty (30) days prior to the date of renewal. I also agree that the authorized credit card information provided below is correct and that I will provide New York Cryo with any changes in this information.

Name on Credit Card: \_\_\_\_\_

Card #: \_\_\_\_\_ Exp.: \_\_\_\_\_

Vcode: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Card Holder: \_\_\_\_\_