CANCER GENETICS INCORPORATED

Request for Installment Plan

Patient Name:	**Telephone Number: ( )**
Address:	**Patient Date of Birth: / /**
City: **State:**	**Zip Code:**
Invoice Number(s):	
CGI Number:	

Please complete all information accurately. The signature of the patient or patient's guardian is required.
Please make sure that check, money order, or credit card information is attached.

I, _____, am requesting an installment payment plan with CGI. I am fully aware of the total cost of my testing is $ _____, and that once my deposit of $100.00 per test has been received along with this request, CGI will provide me with an installment agreement with choices in terms of 3, 6, or 12 months. Upon receipt of that agreement it is my responsibilty to select the terms and return the agreement within 30 days of the date of the agreement. If my agreement is not returned I will be billed for my total bill minus the deposit I have provided today.

Today my physician has ordered: _____

Total Number of Tests: _____

X $100.00 deposit : $ _____

I have attached (please circle) check money order credit card

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Credit Card Information (please circle type)

Visa Mastecard Amex Discover

Credit Card Number : _____

Expiration Date: _____

Name as it appears on credit card: _____

I hereby acknowledge that the above information is true and correct according to the best of my knowledge an belief. I also authorize CGI to charge payment to me as applicable to this agreement. I understand that if that payment is declined I will be responsible for any fees incurred by CGI in accepting that payment, up to and including a $25.00 returned check fee. I understand that if that payment is returned, this agreement is null and void and I must contact CGI immediately to make payment arrangements.

Patient Name (Print): _____

Guardian Name (Print): _____

Responsible Party Signature: _____

Date:_____

Questions about this form? Please contact CGI Billing Department.
Phone: (201) 528-9174
Email: Billing@CGIX.com
Web: www.cancergenetics.com

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