Mycometrics, LLC.
9 Deer Park Dr. Suite K-18
Monmouth Junction, NJ 08852

Mycometrics
From Research to Diagnostics™

Lab ID #:

Invoice #:

Breast Implant Payment Form

Client Information

Name: ______________________________

Phone: ______________________ Mobile: ______________________

Fax: ______________________ Email: ______________________

Payment Information

❖ **Breast Implant Analysis fee:** ☐ $210 USD for one implant; ☐ $420 USD for two implants

❖ **Please check below for the payment type:**

☐ **Check** (Please make your check payable to Mycometrics, LLC)

☐ **Credit Card:** ☐ MasterCard ☐ Visa (Please check one. We only accept MasterCard or Visa)

Credit Card Number: ______________________________

Expiration Date (mmyy): ____________ CID (3 Digit Security Code): ____________

Cardholder Name: ______________________________

Billing Address:

Street Name: ______________________________

City: ______________ State: ______________ Zip Code: ____________

❖ In the event that the check bounces, a $30 USD bounced-check fee will be charged. By signing below, I hereby agree to pay the bounced-check fee if necessary.

❖ I certify that all information above is accurate. By signing below, I hereby authorize collection of payment, and agree to pay, for all charges as indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company so long as the transaction corresponds to the terms indicated in this form. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card, to be charged for the payment of any outstanding balances owed.

Signature: ______________________ **Date:** ______________________

Please Print Name: ______________________

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