

Payment authorization

I hereby confirm that I will pay for the following expenses of the patient:

Only deposit

Complete hospitalization

Upgrade marginal amount

PATIENT INFORMATION

Name

Adress

ZIP, City, Country

I herewith authorize Privatklinik Bethanien to charge my credit card with the amount of CHF

A well legible double-sided copy of my credit card is attached to this form.

CREDIT CARD DETAILS

American Express

MasterCard

Visa

Credit card number

Cardholder

Expiry date

Security code

Signature cardholder

Date
