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SWISS HOSPITAL GROUP

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CREDIT CARD FORM
INTERNATIONAL PATIENTS

Dear customer

We would appreciate an advanced payment for your medical treatment. Therefore, we would like to ask you to provide us with your credit card and bank account details, as this will allow us to deduct the necessary deposit and pay back any remaining balance if necessary.

To be filled in by the patient
With my signature, I hereby authorize the hospital to credit amounts to the following credit card with any excess balance or charge the credit card any outstanding sums, as applicable

Surname _____ **First name** _____

Date of birth _____

Treatment in ☐ Klinik Hirslanden ☐ Klinik Im Park

Kind of credit card ☐ VISA ☐ American Express
☐ MasterCard ☐ others: _____

Surname, first name of card holder _____

Complete card number _____

Credit card expiration date _____

Please transfer any credit balance to the following account (bank or post office giro):

Exact name of bank _____

Bank location / branch _____

Account number _____

Routing number (sort code) _____

IBAN number _____

Name and address _____
of account holder _____
_____

Place / Date _____ Signature _____