



**CENTRE FOR NEURO SKILLS®**

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**AUTHORIZATION TO BILL CREDIT CARD**

DATE \_\_\_\_\_

NAME ON CARD \_\_\_\_\_

E-MAIL \_\_\_\_\_ PHONE # \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

CREDIT CARD TYPE \_\_\_\_\_ VISA \_\_\_\_\_ M/C \_\_\_\_\_ AM EX \_\_\_\_\_

CREDIT CARD ACCOUNT # \_\_\_\_\_

EXP DATE (MMYY) \_\_\_\_\_ CV2 CODE \_\_\_\_\_ (3 digit number on back of card)

**BILLING ADDRESS:**

STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

AMOUNT \_\_\_\_\_ FREQUENCY OF CHARGE \_\_\_\_\_

BEGINNING DATE \_\_\_\_\_ ENDING DATE \_\_\_\_\_

PERIOD OF TIME/DATES OF SERVICE \_\_\_\_\_

I AUTHORIZE CENTRE FOR NEURO SKILLS TO BILL THE ABOVE CREDIT CARD FOR SERVICES RENDERED. I UNDERSTAND THAT MY CARD WILL BE BILLED AT THE FREQUENCY STATED ABOVE UNLESS I MAKE ANOTHER PAYMENT OPTION AVAILABLE. MY CARD DETAILS WILL NOT BE STORED AT THE SERVICE ADDRESS, THEY WILL BE ENCRYPTED ACCORDING TO PCI COMPLIANCE.

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SIGNATURE