NeuroZone

Credit Card Authorization

Date: ___________________________

Patient Name: ____

Credit Card Type: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX

Credit Card Number: ____

Expiration Date: ___________ /___________ (MM/YY) CCID: __________________________

Cardholder Name: ____

Billing Address: ____

City, State: ____ Billing Zip Code:__________________

I, _________________________________ understand that **NeuroZone, Inc. is *not* a preferred provider** for any insurance plans. I agree that I am responsible to pay **NeuroZone, Inc.** I agree to pay above amount according to card issuer agreement.

Cardholder Signature: _______________________________ Date: __________________________

Thank you!