FIRST Choice NEUROLOGY

Recurring Credit Card Authorization Form

Please fax to 786-219-0166

Patient Name: ____

Account Number: ___________________

Credit Card Type: VISA MASTERCARD AMEX DISCOVER

Credit Card Number: ____

Expiration Date: ________________ Security Code (on back of card): ___________

Name as it appears on card: ____

Billing Address on credit card statement: ______________________________________

____

Email Address (you will be emailed when a transaction processes):

____

Total Balance Due: __________________________

Recurring Monthly Payment: _______________ what day of the month? _________

I understand and authorize Neuroscience Consultants LLP to automatically charge my credit card the amount specified above up to the "Total Balance Due". Once my financial obligation is paid in full, Neuroscience Consultants LLP will cease automatic payments.

Card Holder's Signature: _______________________ Date: ___________________

Office Staff: ___________________________________ Date: ___________________

FIRST Choice MRI FIRST Choice THERAPY