Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Card Type:

- ☐ Master Card
- ☐ AMEX
- ☐ Visa
- ☐ Discover
- ☐ Other

Patient Name: _____

Cardholder Name: (as shown on the card)_____

Card Number: _____ CVV Code: _____

Expiration Date: (mm/yy)_____

Cardholder ZIP Code (from credit card billing address)_____

I, _____, authorize Pathways Neuropsychology Associates to charge my credit card above for agreed upon patient responsibilities. I understand that my information will be saved to my secure patient account for future transactions on my account.

_____ _____

Signature Date