Upcounty Neuropsychology, LLC

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CREDIT CARD AUTHORIZATION

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

CREDIT CARD INFORMATION			
CARD NUMBER			
CARDHOLDER NAME (AS SHOWN ON CARD)			
BILLING ADDRESS (INCLUDING ZIP CODE)			
CARD EXPIRATION DATE (MM/YY)		CVV/SECURITY CODE	

I, _____, hereby authorize Upcounty Neuropsychology, LLC, to charge the above credit card for professional fees and related charges incurred in the course of evaluation, assessment, testing, and treatment of the below-named patient. I understand that my information will be saved in the patient's file for future transactions.

_____
PATIENT NAME

_____ _____
CARDHOLDER SIGNATURE Date