# Neuro Harmony, LLC

1836 Victoria Lane Charleston, Il 61920
Phone: 217-508-7953 Email: info@neuroharmony.org

## ENCRYPTED DEBIT OR CREDIT CARD AUTHORIZATION FORM

**Credit Card Information**

Card Type: ☐Mastercard ☐Visa ☐ Discover ☐ Amex ☐ Other_____

Cardholder Name: (as shown on card)_____

Card Number: _____

CVV code on back: _____ Card Expiration: (mm/yy) _____

Cardholder Billing Address: Street: _____

City: _____

State: _____ Zipcode: _____

By signing below, I authorize Neuro Harmony, LLC to encrypt my debit or credit card to be held on file for the account of _____. I am authorizing my card to be charged for any balance incurred on this account including missed appointment fees, monthly late fees, bank retrieval fees, insurance copays, co-insurance or any amount determined to be this patient's responsibility. I understand that these amounts will be charged to may debit or credit card as the expenses are incurred. I understand that my information will be encrypted and held on file for future transactions on this account. I understand that if my card is declined, I will be charged a late fee of $10.00 per month from this day forward until my account is paid in full.

_____

Customer Signature Date

Revised 7/22/19