PLEASE FAX IT BACK TO 619-353-2464

Credit/Debit Card Payment Consent Form

Client Name ____

Print Last *First* *Middle Initial*

Name on Card if different ____

I authorize DR.DANOV NEUROPSYCHOLOGIST P.C./BRAIN ACADEMY CENTER

to charge my card for professional services as follows:

Initial

______ For the amount of $____________________________________

______ All visits in the next 12 months, beginning _____ /_____ /_____,
Each visit $____

______ Recurring charges, date(s) of service _____ /_____ /_____ to
_____ /_____ /_____, each payment $_______________________,
____ monthly, ____ semimonthly, ____ weekly, ____ per visit.

______ to charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.

Type of Card: Amex VISA MasterCard Discover

Exp Date: Month/Year ______/______

Card Number _______ - _______ - _______ - _______ CVV Number ________
(# from back of your card)

Card Holder's FULL/COMPLETE Billing Address for Monthly Card Statements

____

Street *City* *State* *Zip*

If I have questions about these charges, I agree to contact Dr.Danov Neuropsychologist PC/Brain Academy. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay penalty fee of $100.

Card Holder Signature ___________________________ Date ____ /____ /____

Charges will appear on your card statement as an abbreviation of DR.DANOV NEUROPSYCHOLOGIST P.C.