



Palm Beach Neurological Center
3355 Burns Road Suite 201
Palm Beach Gardens, FL 33410

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 cancelled.

Credit Card Information	Patient Name:
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____	
Cardholder Name (as shown on card): _____	
Card Number: _____ CVV: _____	
Expiration Date (mm/yy): _____	
Cardholder ZIP Code (from credit card billing address): _____	

I, _____, authorize _____
to charge my credit card above for agreed upon purchases. I understand that my information will
be saved to file for future transactions on my account.

Customer Signature

Date