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AUTHORIZATION TO CHARGE CREDIT CARD

NAME ON CARD: _____

CARD TYPE: _____

ACCOUNT #: _____

EXPIRATION: _____

SECURITY CODE: _____

ZIP CODE FOR CREDIT CARD: _____

PATIENTS NAME: _____

I HEREBY AUTHORIZE NEUROSCIENCE SPECIALIST TO CHARGE FOR CONSULTS AND FOLLOW-UP VISITS PROVIDED BY DR. ERICKSON or NP JACKSON.

DATE AUTHORIZATION EXPIRES: _____

SIGNATURE_____ DATE_____