Patient Name		
Cardholder Name		
Billing Address		
Billing City, State, Zip		
Billing Phone		
Credit Card	☐ **Visa** ☐ **MasterCard** ☐ **American Express** ☐ **Discover**	
Card Number		
Expiration Date & Authorization Code (3-4 digit code on front/back of card)		
Payment Authorization	_____ **(Initials)** **$450 for single NeuroEyeCoach license**	

The undersigned authorizes the above charges to be drawn on the credit card or debit card noted above.

Account Holder Signature _____Date _____