NovaVision®

PAYMENT FORM VRT & NeuroEyeCoach

Payment Type ☐ Check ☐ Money Order ☐ Credit Card (fill below) ☐ Other

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

Select Payment Option

☐ VRT & NeuroEyeCoach Therapy Suite..... **$950** *($50 refundable deposit for chinrest)*

☐ NeuroEyeCoach.....**$450**

The undersigned authorizes the above charges and any additional charges due pursuant to the patient agreement to be drawn on the credit card or debit card noted above as such charges may become due.

Account Holder Signature _____ Date _____

Phone: 1.888.205.0800 **Fax to:** 1.561.620.2546 **Website:** www.novavision.com