**NAA / Neurologic Arts Associated 183 Highstreet, Suite 1200.,Newton, NJ 07860 973-300-0579 Newtonneurology.com**

**Credit Card Authorization Form**

As a convenience to our clients, we are introducing credit card payments and can now accept MasterCard, Visa, American Express and Discover Credit Cards. Our electronic record system encrypts data and stores credit card information in encrypted format within the system, so that cards can be charged at the time service is rendered.

(Print name in block letters) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Neurologic Arts Associated LLC to charge my credit card for services rendered to me, my family or my child. I understand that:

A. My credit card information will be kept on file.

B. My credit card account will be charged at the time of service including virtual visits/ phone calls.

C. By signing this document I acknowledge that I do not need to be present when my credit card is charged.

I further understand that I may terminate this agreement upon no less than 48 hours’ notice by sending a letter stating I wish to end the automatic authorization Neurologic Arts Associated LLC at the above address.

I am aware that my credit card will be charged for all appointments not paid at the time service is rendered, including missed appointments not cancelled 24\* or (\*48 hours in advance for Monday apts.) as described in the NAA office policy and procedure document which I have read on the Neurologic Arts Associated LLC website or the NAA LLC patient portal. I am aware that other charges may include but are not limited to evaluations and report writing, form fees, records processing which are involved in treatment and phone/ video consultations.

Credit Card: \_\_\_\_\_VISA \_\_\_\_MasterCard \_\_\_\_American Express \_\_\_Discover

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_

3/4 Digit Security Code from back of card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing zip code : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Responsible Party Name as it appears on credit card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I HEREBY AUTHORIZE MY CREDIT CARD TO BE CHARGED FOR SERVICES RENDERED AS STATED ABOVE BY NEUROLOGIC ARTS ASSOCIATED, LLC.**

 Date: \_\_\_/\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_

 Cardholder’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (initial) \_\_\_\_ I will notify NAA,LLC in advance of changes to credit card or bank account information or if my credit card is lost, stolen, cancelled or revoked to avoid being assessed a fee for rejected charges. (Please ask us if you have questions about this agreement.)