NeuroSensory Center of Eastern Pennsylvania
Suite 317 · 250 Pierce Street · Kingston, PA 18704
T: 570.763.0054 F: 570.763.0056
info@keystonensc.com www.keystonensc.com

CREDIT CARD FORM

This form makes payment arrangements more convenient both for you and for us. The resulting reduction in our office expenses can be passed along to our patients, as lower fees for services and for products, such as nutraceuticals. Please take a moment to complete this form.

NeuroSensory Center will only bill your credit card after your insurance company has completed its benefit report, and all benefits to which you are entitled have been paid by your insurance. Any balance that remains following your insurance company's benefit payment will become the patient's responsibility after 30 days, and only at that time will your remaining balance be assigned to your credit card.

NEUROSENSORY CENTER PATIENT NAME(S):________________________________

NAME ON FRONT OF CREDIT CARD: ____

TYPE OF CARD (VISA, MASTER CARD, DISCOVER): ___________________________

CREDIT CARD NUMBER: __________--__________--___________--____________

EXPIRATION DATE (MONTH and YEAR): _____________________________________

THREE/FOUR DIGIT CODE ON BACK OF CARD: ______________________________

MAXIMUM AMOUNT I WANT TO BE BILLED: (Cardholder please initial a single amount)

- $250.00_______ PER MONTH TO REDUCE MY ACCOUNT TO ZERO
- $500.00 _______PER MONTH TO REDUCE MY ACCOUNT TO ZERO
- $750.00 _______PER MONTH TO REDUCE MY ACCOUNT TO ZERO
- FULL AMOUNT REQUIRED ______ TO REDUCE MY ACCOUNT TO ZERO

CARDHOLDER SIGNATURE:______________________________ DATE____________

With my signature, I acknowledge that I am responsible for the credit card listed above, and authorize *NeuroSensory Center of Eastern Pennsylvania* to apply this credit card information to any unpaid balances for the patient(s) listed above.

THIS AUTHORIZATION EXPIRES 24 MONTHS FROM THE DATE ABOVE