PEDIATRIC NEUROPSYCHOLOGY SERVICES, PLLC

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Authorization To Recharge Credit Card

Your initial deposit is due upon testing. However, this form when completed and signed by you authorizes me to recharge the credit card used for your deposit to make the payments on the three additional dates of testing/feedback scheduled.

As indicated, this does not include your first payment deposit which will be made when you book the testing.

I authorize Michelle Lurie, Psy.D.; ABPdN to recharge my credit card on the dates of testing and the feedback session.

_____ _____

Signature of Patient /Guardian Date

Email Address:_____