



**Merlyn Hurd, Ph.D., QEEG-D; ECNS; BCB; BCN Senior Fellow**  
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***Credit Card Authorization Form***

**THIS INFORMATION IS PRIVATE AND CONFIDENTIAL  
AND WILL ONLY BE KEPT ON FILE BY**

Name as it appears on credit card: \_\_\_\_\_

Phone number: \_\_\_\_\_

Billing address of credit card with zip code: \_\_\_\_\_

\_\_\_\_\_

Email address: \_\_\_\_\_

Card (Choose One) \_\_\_ Visa \_\_\_ Master Card \_\_\_ Discover \_\_\_ American Express

Credit Card Number: \_\_\_\_\_

Expiration Date: Month/Year \_\_\_\_\_

CCV OR CID Code: \_\_\_\_\_

All patients are required to have an active credit card on file. Payment is due at the time of service, or at the session following a "no show" defined as a cancellation with less than 24 hours notice. If you prefer to pay by cash or check, please do so at the time of service, or at the session following a "no show." If payment is not received at the time of service or at the next session following a "no show," we will wait five (5) days for a check to be received by mail. After 5 days your credit card will be charged for any balance due.

I hereby authorize this credit card to be used for payments for services rendered by Merlyn Hurd PhD.. This authorization will remain in effect until the expiration date of the card or a written request to revoke the authorization is sent to us at: 928 Broadway, Suite 305 NY, NY 10010.

**Please advise us immediately if your card is lost and/or stolen.**

Card Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

