Credit Card Authorization

This is to authorize Pacific Neurotherapies to maintain my VISA or MasterCard number on file. I understand that Pacific Neurotherapies will keep this number in strictest confidence. For my convenience, you will use this number to charge my supplements, mailed supplement orders, telephone consultation and other charges. I understand I do not need to reauthorize for each order. When this card expires, I will give Pacific Neurotherapies a verbal or written update. Of course, if my card is lost or stolen, I will notify you so that this authorization can be revoked.

Name (Please Print): ____

Credit Card Number: ____ *(All Digits)*

Expiration Date: ________________________________

Signature: ____ Date: ___________