The NeuroGenesis Project

Credit Card on File Authorization Form

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Print Card Holders Name: (As it appears on card)

Card Number:

☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐

Expiration Date: ☐☐ / ☐☐ (Month) (Year)

Security Code: ☐☐☐☐

Zip Code: ☐☐☐☐☐

Card Type:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

I understand that all charges are assessed from Axion NeuroTherapy, Inc.

I have read and agreed to Axion NeuroTherapy, Inc.'s financial policy. I hereby authorize Axion NeuroTherapy, Inc. to charge the credit card listed above for payment of charges to my account. All unpaid deposits and balances are authorized by the credit card holder by signed acceptance of this contract. All accounts not paid as due and agreed upon here will be charged interest at a maximum annual percentage rate (APR) of 18%. If this agreement is placed in the hands of an attorney and/or collection agency, the undersigned agrees to pay all costs.

This form will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may also revoke this form by submitting a written request to the address listed below.

A new form must be submitted if information such as the list of authorized users and the credit card account's expiration date is amended. The applicant must also submit a written notification to Axion NeuroTherapy, Inc. if the credit card is cancelled, lost, or stolen.

_____

Card Holder's Signature

_____

Date

CENTER FOR BRAIN CARE
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