

Cerebro, Inc.
1510 Columbine Ave.
Boulder, CO 80302
tel: 303.586.1556 fax:303.747.5726
www.rwinermd.com

Credit Card Authorization Page 1

Card Type:

Name on Card:

Card Number:

Expiration Date:

CVV Code on card (see picture below for location):

Billing Address (include zip code):

Billing Address phone number:



Visa/MasterCard/Discover

A 3 digit number on the back of your card near your signature



American Express

A 4 digit number on the front, right-hand side of your card that is printed above your card number.

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Credit Card Authorization Page 2

I authorize Cerebro, Inc. to charge the above card for administrative, consultative, medical, psychiatric, psychoanalytical, psychopharmacological, or psychological services rendered to me or my family member (see attached charges). If the card used is not in my name I am authorized to use this card by virtue of my relationship with the card holder or because I am listed on the account. I understand that Merchant Services fees are added into this charge.

You may specify (below) which invoice you are paying (include date and amount):

OR

By leaving the above space blank, authorize payment for the present and future invoices

Please sign below:

Signature of Patient (if able to sign)

Date

Signature of Card Holder (if present)

Date