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Please Note: For your convenience we are offering credit card payment option.
To pay your bill by credit card, use this form. Complete and return the following:

Patient Name: _____ Phone No: _____ _____

Account Number: _____ Amount: _____
(Located in top right corner of bill)

Credit Card Type: ☐ **Visa** ☐ **Mastercard** ☐ **Discover**

Credit Card No: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: __ __ / __ __ CVV code: __ __ __ (3 digit security code on the back of card)

I hereby authorize Tim K. Cha, MD Neurology Medical Corporation to charge my credit card for the amount stated above as payment for the medical service rendered.

Print Name on Card: _____ Signature:_____

***** Make sure you sign.**

You may mail this to the office address, fax, or scan and send it to the e-mail address as above in any which way you prefer. Thank you very much for your payment.