

**Donation Credit Card Authorization Form**

*All donations are tax-deductible*

Please print this form and mail, fax, or email to:

Association for Comprehensive NeuroTherapy (or ACN)

PO Box 2198, Broken Arrow OK 74013

Email Address: [ACN@Latitudes.org](mailto:ACN@Latitudes.org) Fax Number: 1-561-798-9820

**Please write clearly**

YOUR NAME: \_\_\_\_\_

CARDHOLDER'S NAME: \_\_\_\_\_

**Type Of Card (circle):**

DISCOVER AMEX VISA MasterCard

Card Number: \_\_\_\_\_ Expiration Date: *Month* \_\_\_\_\_ *Year* \_\_\_\_\_

BILLING ADDRESS (this address must match the credit card billing address):

STREET: \_\_\_\_\_

CITY \_\_\_\_\_ STATE/PROVINCE: \_\_\_\_\_

POSTAL CODE \_\_\_\_\_ COUNTRY \_\_\_\_\_

PHONE (for billing question only): \_\_\_\_\_

YOUR E-MAIL ADDRESS \_\_\_\_\_

I verify that all information is correctly provided, and that I, the undersigned, am the card holder of the above credit card. I authorize Association for Comprehensive NeuroTherapy, Inc to charge my indicated credit card, without an imprint, for the amount of:

US DOLLARS (FIGURES ONLY) \$ \_\_\_\_\_

US DOLLARS (WORDS ONLY) \_\_\_\_\_

CARDHOLDER'S SIGNATURE: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_