Directions CLS, LLC
20 Community Place, Suite 400
Morristown NJ 07960
Office: 973-425-8868

AUTHORIZATION FOR USE OF CHARGE CARD BY:

Directions CLS, LLC

Please note we accept: Visa, MasterCard, Discover

Patient/Client's _____ Date: ___/___/___
Name (print)

Amount of Charge: _____Date of Charge ___/___/___

Reason for Charge: _____

Visa: _____ MasterCard: _____ Discover: _____

Credit Card Billing Address: _____Zip code _____

Expiration Date: _____ 3 or 4 Digit Security Code: _____

Card Holder's Name: _____

Credit Card Number:_____

I give permission to Directions CLS, LLC to charge the above dollar amount to my credit card. I am aware that, in accordance with the Financial Agreement, all fees and payments are non-refundable.
_____ (Card Holder's Initials)

Cardholder's Signature: _____Date ____/____/_____

FAX: 973-539-3687 OR E-MAIL: drthorpe@directions-cls.com