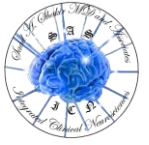


SAAD A. SHAKIR, M.D., D.F.A.P.A., F.A.C.I.P. AND ASSOCIATES
INTEGRATED CLINICAL NEUROSCIENCES and SILICON VALLEY TMS

Diplomate, American Board of Psychiatry and Neurology, Distinguished Fellow of American Psychiatric Association
Adjunct Clinical Associate Professor Emeritus, Stanford University, School of Medicine



Credit Card Authorization Form

I, _____, hereby authorize Saad A. Shakir M.D. and Associates Inc, to charge my credit card for the amounts invoiced.

Patient's Name: _____

Name on card: _____
(If different from patient's Name)

Type of Card: AMERICAN EXPRESS / DISCOVER / VISA / MasterCard / OTHER
If other, please specify: _____

Credit Card Number: _____

Expiration Date: _____

CVC Code: _____

Credit Card Billing Address

Street: _____

City: _____

State: _____

Zip Code: _____

Telephone: _____

Email (optimal): _____

As the credit card holder, I also authorize Saad A. Shakir M.D. and Associates Inc. to charge my credit card for future services and also for late cancellations or failed appointments.

Your completion of this authorization form helps us to protect you, our valued patients, from credit card fraud. Saad A. Shakir M.D. and Associates Inc. will keep all information entered on this form strictly confidential.

Cardholder's Signature

Date