CROSSROADS Behavioral Health, LLC

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MASTERCARD/VISA AUTHORIZATION AGREEMENT
For The Highlands Ability Battery and Vision Program

MASTERCARD/VISA: #_____

Expiration Date: _____

Last 3 Digits of Security Code (on back of card): _____

Billing Address: _____
Street

_____
City, State Zip Code

I, _____ authorize Crossroads Behavioral Health, LLC to submit charges to my ____MASTERCARD or ____VISA for the **Highlands Ability Test Battery or The Highlands Don't Waste Your Talent Vision Program**. I understand that once I have been sent the registration key(s), this fee is not refundable.

_____ _____
Date Client Signature