CLIMB Membership Payment Options

I hereby authorize The Indiana Parkinson Foundation to charge my account as indicated below. The credit card or debit card on file will be charged on the 1st of each month.

If the client wishes to discontinue membership written communication needs to be submitted to the Program Manager.

Billing Options

☐ $30/month for Parkinson's members
☐ $10/month for caregivers, spouses

Card Type

☐ Visa ☐ Mastercard ☐ Discover

Billing Period (Recurring Monthly) _____ **Amount to Bill Card** _____

Member's First Name _____ **Member's Last Name** _____

Cardholder's First Name _____ **Cardholder's Last Name** _____

Card Number (16 Digits) _____ **Expiration Date (Month/Yr)** _____

CSV (3 digit on back of card) _____

Cardholder's Billing Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Email** _____

Authorized Card Signature

_____

IPF Staff Member Signature

_____

Date Signed _____

Date Processed _____

Notes