CREDIT CARD AUTORIZATION FORM

In providing us with your credit card information, you are giving *Child & Family Counseling Group* permission to automatically charge your credit card on file for your charges [or any other patient(s) you have listed on this form]. By signing this you authorize this agreement will remain in effect until the end of treatment.

CFCG Provider(s) Name:

_____

_____

_____

I authorize Child & Family Counseling Group, to charge service payments and outstanding balances on my account to the following credit card:

Visa	MasterCard	Discover	Amex	HSA/FSA
☐	☐	☐	☐	☐

Card Holder Name: _____ Card Number: _____/_____/_____/_____

Expiration Date: _____/_____/_____ CVC Code: _____

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

Patient Full Name: _____ Date of Birth: _____/_____/_____
(Please Print)

Patient Full Name: _____ Date of Birth: _____/_____/_____

Patient Full Name: _____ Date of Birth: _____/_____/_____

Note to Office:

Responsible Party Signature: _____ Date: _____/_____/_____

Phone Number: _____ Email Address: _____