CHILD & FAMILY COUNSELING GROUP
Comprehensive Diagnostic & Therapeutic Services

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] at the end of each month.

By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request. Temporary arrangements for this agreement should be noted on this form. ***Please note that there will be a $10 convenience fee charged for your monthly authorization.***

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 ☐ HSA/FSA ☐

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

Contact Number: _____ Billing Zip Code: _____

Expiration Date: _____/_____/_____ CVC Code (3 digits): _____

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: _____/_____/_____

TEMPORARY USE ONLY: ONE DAY ☐ **CUSTOM AGREEMENT TERMINATION DATE:** _____/_____/_____

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

CFCG Authorized Signature: _____ Date: _____/_____/_____

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