Credit Card Authorization Form

I authorize Child & Family Counseling Group, P.L.C. lo charge my credit card for all amounts owed for services rendered by CFCG Provider(s):

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Patients Name(s):	Patients D.O.B.

Card Holder Name ________________________

Contact Number ________________________

Authorization Type *(please check one)*

- ○ One time
- ○ Monthly *(billed once per month for total balance)* Authorization Valid thru: _______

Credit Card Billing Address:

____

____

Credit Card Number *(Visa, MC, Discover Only):* ___________________________________

Expiration Date: _______________

CCV: ______

Signature: _________________________________ Today's Date: ____________________