Craine Counseling and Consulting Group
Ellen M. Craine, JD, LMSW, ACSW, INHC
Credit Card Authorization Form

FOR OFFICE USE ONLY CUSTOMER# DATE:

Effective Date of Authorization:

Type of Authorization Form (select one): ☐ New Authorization

☐ Change Payment Amount

☐ Change Payment Date

☐ Change Payment Information (CC # Change)

☐ Discontinue Electronic Payment

Last Name: First Name:

Street Address:

City: State: Zip:

Payment Amount: Payment Date:

Monthly Recurring Payment:
Automatic Recurring Payment on the _____ of each month

I authorize the Craine Counseling and Consulting Group to process credit card payments as stated above. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature:_____

Date:_____

Please charge my payments to my (circle one): Visa ☐ ☐ MasterCard American Express ☐
Discover Card ☐

Credit Card Number: Expiration Date:

Name on Card: Security Code:

Billing Address (if different from above):

I authorize the above company to charge my credit card in accordance with the information above: