CRAINE COUNSELING AND CONSULTING GROUP
ELLEN M. CRAINE, JD, LMSW-Clinical and Macro, ACSW, INHC

Credit Card Authorization Form

FOR OFFICE USE ONLY CUSTOMER# DATE:

Effective Date of Authorization:

Type of Authorization Form (Select 1):
- ☐ 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

Please charge my payments to my (select 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 Ellen M. Craine and 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:___________________________