Counseling *Specialists*
OF CENTRAL FLORIDA

CREDIT CARD AUTHORIZATION FORM

CREDIT CARD INFORMATION

☐ Visa
☐ Master Card
☐ American Express
☐ Discover

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

Billing Street Address: _____

AUTHORIZATION

I, _____ authorize Counseling Specialists to charge my above stated credit card for services rendered to the following individual(s):

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____
5. _____ Relationship: _____

I understand that this credit card information will be placed on file to cover current, future, and any outstanding past transactions for the above stated individual(s). I also acknowledge that future transactions will be billed at the time the services are rendered, unless otherwise agreed upon in writing.

SIGNATURE

_____ _____
Signature of Client, Parent, or Legal Guardian Date

_____ _____
Printed Name of Client, Parent, or Legal Guardian Relationship to the Client/Minor