Payment Authorization Form

Please complete all fields, print, and sign the bottom of this page. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

**PLEASE COMPLETE ONE OR BOTH FOR YOUR CHOICE OF PAYMENT.**

|  |  |
| --- | --- |
| **Credit Card Information** | |
| Card Type | (select one) |
| Cardholder Name  (as it appears on card) |  |
| Card Number |  |
| Expiration Date |  |
| CVV (3-digit code) |  |
| Billing Street Address |  |
| Billing City, State, & Zip Code |  |
| Cardholder Email Address |  |
| Cardholder Phone Number |  |

I, , authorize D’Amico & Associates in Counseling to charge my credit card for agreed upon services. I understand that a **convenience fee** will be added to each credit card transaction (fee schedule available upon request). I understand that my information will be saved to file for future transactions on my account.

|  |  |
| --- | --- |
| **Checking Account Information (for E-Checks)** | |
| Account Holder Name  (as it appears on checks) |  |
| Routing Number |  |
| Account Number |  |
| Account Holder Phone Number |  |

I, , authorize D’Amico & Associates in Counseling to charge my e-check account for agreed upon services. I understand that a **convenience fee** will be added to each e-check transaction (fee schedule available upon request). I understand that my information will be saved to file for future transactions on my account.

Agreed upon services for the following clients are authorized to be charged to this credit card or E-check account:

|  |  |
| --- | --- |
| **Authorized Client List** | |
| (Client Name) | (Client Name) |
| (Client Name) | (Client Name) |
| (Client Name) | (Client Name) |

Signature:      Date:      /     /