



### **Credit Card Authorization on File**

Please complete this form if you would like **Hope Restored Counseling Services** to keep your credit card on file for future payments. You may elect to provide us with credit card information separately for each payment. Information to be completed by the card holder:

Client's Name: \_\_\_\_\_

Card Number: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Card Type (please circle): Visa MasterCard Discover AmExpress

Expiration Date: \_\_\_\_\_

Security Code: (3 digit code on back) \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

I, \_\_\_\_\_, authorize **Hope Restored Counseling Services** to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature: \_\_\_\_\_