



MACHIEL KLERK

CREDIT CARD AUTHORIZATION FORM

All information provided on this form will be kept confidential. Please read all sections carefully. If you have any questions, please contact your Machiel before signing.

Payment Frequency:

- One Time Payment: Bill my credit card once for the following amount \$ _____
- Repeat Payment: automatically charge my credit card _____ per session for the service provided
- Other: _____

Credit Card Information:

Name (as it appears on card): _____

Credit Card Number: _____

Expiration Date: ____/____ CVC Number (on back of card): _____

Billing Address: _____

City/State/Zip: _____

Email Address: _____

I authorize Machiel Klerk, LMFT to charge the above referenced credit card account and apply said charges toward the payment of services rendered. I certify that the above information is accurate and acknowledge that Family Guiding may seek alternative form of payment if charges are declined or charge backs are claimed against any outstanding invoice. I understand that it is my obligation to notify Family Guiding of any changes in the status of this card.

(Printed Name)

(Signature of Authorized Individual)

(Date)