Sullivan Counseling Incorporated

Credit Card Authorization Form

THIS INFORMATION IS PRIVATE AND CONFIDENTIAL AND WILL ONLY BE KEPT ON FILE BY:

Jaclyn J. Sullivan, MA, LMFT

Name as it appears on the card: ____

Phone Number: ____

Billing Address of card with **ZIP** code: ____

Type of Card (Check One): □ Visa □ Master Card □ Discover □ American Express

Card Number:____

Expiration Date (Month/Year):____

CCV or CID Code: ____

Payment Amount: ____

I hereby authorize this credit card to be used for payments for services rendered by Sullivan Counseling Incorporated.

This authorization will remain in effect until the expiration date of the card or a written request to revoke the authorization is sent to us directly with explanation to 21 Greene Ave. Amityville, NY 11701.

Please advise us immediately if your card is lost and/or stolen

Card Holders Signature__________________________________ Date: ________________________