The Christian Counseling Center
Of First Presbyterian Church

Electronic Payment Authorization

Please complete the following information, which will be securely stored in your clinical file and may be updated upon request at any time.

I,_____ give permission to have my credit/debit card charged for an appointment, missed appointment, or any unpaid balances.
I understand I will be notified prior to any charge.

Client Information

Client Name:_____

Name as shown on the Credit Card:_____

Billing Address:_____

City/State:_____ Zip:_____

Phone Number:_____

Email: _____

Account Information

Visa____ MasterCard____ American Express____ Discover____ Debit____

Card Number:_____

Expiration Date_____

Billing Zip:_____ Security Code (CCV): _____

_____ _____

Signature Date