Lantern Therapy Services, LTD

Credit Card Recurring Payment Authorization Form

Schedule your payments to be automatically charged to your credit card.

I_____ authorize Lantern Therapy Services, LTD to charge my credit card indicated below for payment of counseling fees.

Billing Address_____ Phone#_____

City, State, Zip_____ Email_____

Account Type: ___Visa ___Mastercard ___Amex ____Discover
Cardholder Name_____
Account Number_____
Expiration Date_____
CVV_____

Signature_____ Date_____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that the authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization. This payment authorization is the the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

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