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
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.

Crystal Lake and Rockford IL
Phone: 815-564-8633 Fax: 779-423-0778