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Credit Card Authorization

I _____ (name as it appears on card) authorize the use of my credit/debit card described below for charges related to services provided by Elizabeth Armstrong, LMFT #111154 (DBA "Growing Brighter Therapy.")

Credit Card Type:

MasterCard

Visa

American Express

Discover

Credit Card Number:

Expiration Date: ____ / ____ / ____

CVV number: _____

Name of Cardholder:

Name of Client (if different):

Credit Card Billing Address:

Street

City

State

Zip Code

Cardholder Signature

Date