**Credit card Update Form**

You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Therapist Name:

**Credit Card Info:**

Type of Card:

Cardholder Name:

Phone # / Email:

Card Number:

Expiration Date (MM/YY):

Security Code:

Zip Code:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Center for authentic Living, to charge my credit card above for agreed upon purchases. I understand that my information will be saved to a file for future transactions on my account.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Cardholder Signature Date