Recurring Credit Card Authorization form

I _________________________ authorize Erika Engel Psychotherapy Prof Corp to charge my
(Cardholder's Name) (Merchant's Name)
Credit Card indicated below for $_______ + HST after each session.

I agree that no prior notification will be provided before my card is charged, unless the date or amount changes. If this event occurs, Erika Engel Psychotherapy Prof Corp sends a notification at least 10 days prior to the payment being collected.

This payment is for ☒ Psychotherapy sessions. ☐ Coaching sessions.

Recurring Charge –
By signing this form, you:
- Authorize regularly scheduled charges to your credit card.
- Will be charged the amount indicated above for each billing period.
- A receipt for each payment will be provided to you and the charge will appear on your credit card.

Billing Information

Phone # ________________________ Email __________________________

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other ______________________________
Cardholder Name (as shown on card): ______________________________
Card Number: ______________________________
Expiration Date (mm/yy): ______________________________ CVV____________
Cardholder Billing address with Postal Code (from credit card billing address): ______________________________

Consent:

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Erika Engel at Erika.engel@me.com in writing of any changes in my account information or termination of this authorization at least 10 days prior to the next billing date. 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 acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of Canadian law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE ______________________________ DATE _______________________
(Cardholder's Signature)

Please password protect this document before sending it.

Please share the password by texting at 416-418-2508.

Protect a document with a password

1. Go to File > Info > Protect **Document** > Encrypt with **Password**.
2. Type a **password**, then type it again to confirm it.
3. Save the file to make sure the **password** takes effect.