ANGEL CARE HOME COMPANION SERVICES, INC.

CLIENT PAYMENT AUTHORIZATION:

Clients Name: ____

☐ **For New Clients Only:** I wish to pay my advance deposit of $________________

☐ I wish to **AUTO-PAY:**

☐ Weekly Service Fee of $ _____________________

☐ Bi-Weekly Service Fee of $ ___________________

☐ Monthly Service Fee of $ _____________________

Name of the Account: ____

Relationship to Client: ____

Card: ____

Account Number: ____

EXP DATE: __________________________ **CVV:** ________________________

Billing Address: ____

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____________________________________ ________________________

Signature **Date**