



232 Main Street  
Port Washington, NY 11050

## CREDIT CARD AUTHORIZATION FORM

I hereby authorize Port Washington Children's Center to charge my fees for *(indicate child's/children's full name)*:

\_\_\_\_\_

to my credit card. The credit card information is as follows:

Credit Card Type *(check one)*:

Visa	AMEX	MasterCard	Discover
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Card Number:			
Exp Date:		Security Code:	
Email Address:			
Phone Number:			
Billing Address:			
Town:		Zip Code:	

Amount: \$ \_\_\_\_\_

One Time: \_\_\_\_\_ Monthly: \_\_\_\_\_

Print Name of Cardholder: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_