

# ENT OF SOUTHEASTERN CT

## Credit Card Authorization Form

**DATE:** \_\_\_\_\_

**NAME:** \_\_\_\_\_

**ACCOUNT NUMBER:** \_\_\_\_\_

I authorize ENT OF S. EASTERN CT to automatically charge

\$ \_\_\_\_\_ per month to my credit card in payment of my

balance due. The charge will be made on the \_\_\_\_\_ day of each

month.

**CARD TYPE: (Please Circle One)**

**VISA      MASTER CARD**

**NAME OF CARDHOLDER** \_\_\_\_\_

**CARD NUMBER:** \_\_\_\_\_

**EXPIRATION DATE:** \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE**