New Credit Restoration Client
Payment Authorization Form

Card Holder Name	
Card Number	
Card Expiration Date	___ ___ / ___ ___
3 Digit Security Code	___ ___ ___
Billing Zip Code	___ ___ ___ ___ ___

I, _______________________________, authorize AccountPro Services to charge
(PRINT - FULL LEGAL NAME)

$______________ each month on the _____ of each month for credit restoration
(SERVICE FEE AMOUNT) **(DAY)**

services. I will submit in writing the request to cancel these services at any time and at no additional charge.

___________________________ ________________

Authorized Card Holder Signature **Date**

Email lucia.diaz-gajadhar@accountprosvcs.com for account status or cancellation requests